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Original Articles.

THE TREATMENT OF RETAINED PLACENTA AFTER ABORTION.

A Paper read before the Indiana State Medical Society, May, 1883, by
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In the Cincinnati LANCET AND CLINIC for Dec. 9th. 1882, I published the following article in relation to this topic. In reproducing however, I have, in a manner, revised it:—

It being my intention to present the above subject to the next meeting of the Indiana State Medical Society for discussion, I desire now to introduce it to the profession generally in order that between this and the date of said meeting, I may profit by the criticisms and comments its present treatment may possibly receive. I will be glad therefore to receive any and all literature pertaining thereto, which the reader may have in his possession.

It is unnecessary to tax the patience of the reader with an exhaustive report of the opinions advanced by our standard authorities upon this most important, practical subject. They are almost a unit in the advocacy of the primary extraction of the placenta without leaving the result to nature. Those which I have consulted—a very large majority of them—teach us “that absorption of putrilage from retained secundines is the most frequent sequel in abortion; that possible accidents from manipulation are not a sufficient reason for permitting a placenta to be removed by decomposition, and that by its early removal, septicemia is therefore prevented.” These authorities go so far as to say that “metritis can rarely be traced to direct mechanical violence. If lesions have occurred in the process of extraction, say they, infection in an empty uterus must be slight when compared with one in which the entire surface is exposed and covered by a decomposing placenta.”

At no little risk then, of appearing arrogant, presumptuous or pessimistic, I desire to record most emphatically, my dissent from these views. I am orthodoxically disposed as long as the doctrines taught by our leaders are in perfect harmony with honest experience and what I conceive to be natural, common sense. Unlike law and theology, it is the pride

and boast of our profession that its every member is at perfect liberty to dispute any and all authority. If a lawyer should, with bold and thoughtless assurance call in question a decision of Chief Justice Waite, he would probably be treated with contempt by both the bar and the community. But the most ignorant pretender in medicine is not only allowed but not infrequently expected to set up a bold front against the entire coterie of standard authors. This liberty, if not abused, is by no means unproductive of good. An excessive devotion to authority and established routine has ever been the means of opposing the progress of reason, the advancement of natural truths and the prosecution of new discoveries.

An excessive exercise of this liberty however, is prone to keep up a constant excitement in the profession, and to continue it in a condition of unrest. There is therefore, a strong temptation to many of us to act the part of a mere spectator: to look on indifferently and allow the profession to "wag as it will." Instead of lending a helping hand in the labor of investigation, we believe and adopt everything written or spoken without so much as referring directly or indirectly to the evidence upon which our doctrines are founded. There is, therefore, the more necessity of instituting that cautious observation which is the only preventive of error.

The profession should disabuse itself of the idea that it cannot err if it but implicitly obeys the dogmas of authority. In the most barbarous ages of antiquity the physician was punished or rewarded according to the extent of his success, but to escape retribution it was only necessary to show that an orthodox plan of treatment had been followed, such as was prescribed by some acknowledged authority. We are therefore addicted to routine because it is always easier and sometimes safer in a legal point of view, to follow the opinions of others than to reason and judge for ourselves.

We occasionally have an address, a paper or an editorial upon the subject of "the progress of medicine" of "medical education" of "the relations of christianity to the practice of medicine" or upon the question "is medicine a science?", and the reader has no doubt heard or seen it affirmed by the medical speaker or writer, that it is by observation and experience that we progress as a profession. This is true; the medical profession corrects my experience the errors into which it has been led.

Our experience, however, may be erroneous. It may be unintelligent. It may be innocently or wittingly based upon false premises. It may be made subservient to that proud ambition so prevalent in our profession, to be the originator of a particular theory or mode of treatment—to be the only man living that has accomplished this or that, or to figure prominently in the medical literature of the day, as an authority upon a special subject;

It cannot be denied that we are unable upon all occasions to appreciate the efforts of nature in the cure of disease. This fact must always render our notions in regard to the powers of art, liable to numerous errors and multiplied deceptions. It is as natural as it is often erroneous to attribute the cure of a disease to the last medicine administered, or its prevention to certain measures adopted for that purpose.

All along down through the history of medicine every devotee thereof relies upon experience. The advocates of amulets and charms have pointed to the testimony of what they are pleased to term experience in justification of their superstitious practice. The homœopath, the hydropath, the electropath, the electric and the regular physician all alike appeal to experience in support of their claims to the respectful consideration of the public, and thus many cases which were but most lucky escapes, have been triumphantly regarded as skillful cures, and in this way have medicines, measures and physicians aquired unmerited praise or unjust censure. But we are wandering from our text and will therefore return to it, trusting that the digression will be pardoned.

In the city of Fort Wayne, Indiana, in the month of March, 1876, Thomas Ryan, residing on Baker street, called at the house of the writer hereof, to have him visit his wife. We complied with his request in due time, and upon our arrival, found her delirious, in the dorsal decubitus, with her knees drawn up and her abdomen greatly tympanitic. Her pulse beat feebly at the rate of 150 per minute, her tongue was brown and dry, pupils widely dilated, and the well-known but indescribable putrid odor was emanating from her person. Having broken but a short time prior to this visit, our thermometer, her temperature was not taken. Why it is that our manufacturers of this instrument do not furnish a padded case for each, or adopt some precautionary measure against breakage, I can not determine unless it be that such a course would decrease largely the number sold. In every instance my thermometers have been broken *in their cases*. I wish here to remark, also parenthetically, that I do not regard a rise of temperature an invariable indication of septic infection. I have seen it mark 105.5 and felt the pulse beat 100-120 per minute in the primiparæ, at full term, when there were no other symptoms to correspond or to point to either septic or malarial poison, and where convalescence was promptly established.

Previous to our visit we had gleaned from Mr. Ryan the following history of her case:—Somewhere between four-and-a-half and five-and-a-half months of utero-gestation, she aborted. The placenta not having come away as soon as was desirable, the cord alone yielding to considerable traction, her physician informed her that he would be obliged to extract it with instruments or it would become putrid, and, by absorption, poison her blood and most likely prove fatal. Accordingly, with the assistance of a brother practitioner, he placed her under the influence of an

anæsthetic, and, with the placental forceps, extracted it in pieces, no little force being required to accomplish its detachment. In the course of a few hours thereafter, she was attacked with a violent chill, followed by high fever—her temperature no doubt having been considerably elevated *during* the chill—, pain and tenderness over the uterine region, great thirst and a rapid pulse. From this period she grew worse rapidly, her symptoms becoming more and more alarming until her physicians pronounced her beyond all hope of recovery, when they were discharged and the writer hereof sent for. Our prognosis was equally unfavorable: we did not entertain the slightest idea of a successful issue. We instituted however, the following treatment:—

R Opii pulv. - - - - - grs. ix.
 Quin. sulph. - - - - - ʒss.
 Ft. pulva. et in ch. no vi div. et.

Sig. A powder every four hours. M.

R Tr. ferri chlor. - - - - - fʒ ij.
 Spts. æth. nit. - - - - - fʒ iv.
 Vin. xerrixi q.s. add - - - - - fʒ iv. M.

Sig. A tablespoonful in water two hours after each powder.

In addition to the foregoing, we ordered a large flaxseed poultice to be placed over the abdomen, and the following vaginal—and possibly uterine—detergent and antiseptic injection:—

R Acid carbol. cryst. - - - - - fʒss.
 Glycerine - - - - - fʒ iij ss.
 Tr. opii - - - - - fʒ iv. M.

Sig. Add one or two tablespoonfuls to three pints of water as hot as can be borne, and use as directed, night and morning.

To the utter astonishment of the friends and the writer, she finally recovered.

Seven years have passed away since this memorable case occurred. I say memorable, because presenting itself as it did, in the first years of my practice, it afforded me a most instructive, experimental lesson, and an opportunity to test, at another physician's expense, the soundness of the authorities upon this important question. We have yet to make use of the placental forceps and we opine that we never will employ them. Our impulsive though positive disapproval of the course of treatment pursued by our predecessor, was the honest and natural result of its conflict with what we conceived to be sober reason, a position which subsequent experience has fully sustained. It is because of the recent occurrence of another and very similar case that I considered it proper to introduce the subject to the notice of the profession. In order that the case I am about to relate may become better understood, allow me to preface it with a short introduction:—

In the early part of last September, Mrs. A.—, having missed several menstrual periods, was delighted in the hope and belief that she was

pregnant with her fourth child, herself and husband, be it said to their everlasting credit, being desirous for another babe. But alas! soon after thus giving expression to her joy in the happiness in store for her, she miscarried, the foetus having been expelled and the placenta retained. Her husband called upon us to know what to do concerning the latter. We advised him to keep her quiet, give her a teaspoonful of the fluid extract of ergot every two or three hours, an occasional dose of quinine, to use carbolized injections if any disagreeable odor was detected, and, if the pains were very distressing, to give a teaspoonful or two of paregoric as often as may be deemed necessary. In due time the placenta came away and she progressed nicely to her normal condition without an untoward symptom. We did not even make her a single visit.

During the first week of the following October, Mrs. B.—, a very intimate friend and neighbor of Mrs. A.—, aborted also, under circumstances exactly similar to those under which Mrs. A.— miscarried, and therefore need not be repeated. Her physician, a homœopathic practitioner. I informed her in the presence of Mrs. A.—, that unless he extracted the placenta instrumentally, she would be in danger of blood-poisoning from absorption of the products of its decomposition. This announcement caused a severe shock to the nervous system of Mrs. A.—, as she very naturally reflected upon the great danger she herself escaped, and formed the basis of a few animadversions upon the ignorance and negligence of her own physician, which were by no means pleasant. The forceps were, therefore, employed, the placenta torn away from its attachments, and the doctor left his patient, proud in the thought of not only having actually done a big thing, but of having made a very favorable impression upon the patient of another physician. This impression, however, if created, was of short duration, for at this writing, November 26th, his patient is still upon her back, and his bill, if correctly itemized, will include treatment for metritis, endometritis, peritonitis, phlebitis, retroversion, anteversion, partial inversion, prolapsus, hyperplasia, leucorrhœa, etc. etc. ad infinitum. Can it be possible, I ask, that Nature, so full of the most exquisite and intelligent design, has failed to make any provision for these cases? Who that has contemplated the infinite wisdom displayed in the construction of the human organism, of the eye or of the ear, can believe for an instant that the same supreme intelligence is in no manner successfully prepared for such emergencies?

He assists nature best who assists her in her own way. The question is then, which constitutes the most natural assistance: the use of the placental forceps or the placing of the patient in the most favorable hygienic and sanitary condition, the adoption of such measures as will aid her constitutionally to throw off in due time the foreign material and render non-infections the products of its decomposition. The nearer the apple upon the parent tree approaches maturity, the more readily it is

plucked. Reasoning thus by analogy, the earlier the period at which an abortion takes place, the more tenaciously will the placenta adhere to the walls of the uterus and the greater force will therefore be required to effect its detachment. *The greater the force required to accomplish its separation, the greater the danger of setting up inflammation at, and of its rapid spread from the site of adhesion.*

Immediately following the rupture of the membranes and the expulsion of the foetus, the adherent placenta becomes a foreign body; it is now dead tissue to be cast off gently by the reconstructing forces of nature, the vis medicatrix naturæ, and not to be jerked or torn off violently by the forceps in the hands of the meddlesome physician. Something is necessary to be done by nature upon the living surface of the uterus and upon the dead surface of the adherent placenta, a line of demarcation is to be formed in order to insure a healthy sloughing or its safe separation in the normal order. A little time is therefore necessary for the accomplishment of this object. To tear away *forcibly* the placenta is to place the patient in a traumatic condition with all which that condition implies, and traumatism implies inflammation, the danger of its spread, of septicæmia and pyæmia.

Verneuil, of Paris, has advanced the theory that in the traumatic condition a virus is formed peculiar to that condition, by which deviations from the healthy process of repair of wounds is to be explained.

But, it may be said, the patient is already in the condition of traumatism. This is not strictly true in the common acceptation of the term. After an ordinary, natural delivery at full term the patient can hardly be regarded as being in a much less pathological condition than she would be from the expulsion of the foetus at any previous period of utero-gestation. We will suppose, however, that she *is* in a more or less pathological condition: does this supposition constitute a plausible or sufficient reason why we should increase or intensify that condition and render it one of positive, pronounced and unmistakable traumatism by tearing away *forcibly*, the afterbirth? In the sense in which we are now considering this subject, it is not always true that:—

“ There is a Divinity which shapes our ends
Rough hew them how we will.”

Even Divinity Himself, not infrequently fails in His efforts to “shape up” the “rough work” of the meddlesome physician.

The theory upon which the immediate extraction of the placenta is founded is very plausible indeed, and there can be no doubt that in some instances death has been caused indirectly by its retention; these instances, however, are but exceptions, proving the general rule or the position we assume, and are more than counterbalanced, perhaps, by those in which death has occurred as a direct result from efforts a

forcible extraction. We scarcely pick up a newspaper of the day but that we find recorded therein a death from criminal abortion, not so much due, as I am persuaded, to the manipulation which causes the expulsion of the foetus, as to the intense anxiety *to rid as speedily as possible* the uterine cavity of every vestige of criminal intent. But we hold that *as a rule* the danger of blood-poisoning is more apparent than real in these instances. The very condition of things in these cases is opposed to the process of absorption; the womb is now in a condition more favorable to exosmosis than to endosmosis; to drainage than to stagnation. Tilt says that the vagina has much less power of absorption than the rectum. In a table of fifty-seven cases recently published by Dr. Paul F. Mundé, and to which we shall presently refer, in five of them only were there present symptoms of septicemia, calling for removal of the retained secundines, thus sustaining our position, we think, that the danger of blood infection is not so great in these cases as has been so frequently represented.

In fifty-two of the above cases, hemorrhage constituted the emergency.

Of all the measures calculated to insure a successful issue in these cases the principle of drainage stands pre-eminent. It is undoubtedly the principle upon which the Great Creator designed and constructed the human organism, for a moment's thought will remind us that it embraces millions of sewers. Hence, the most rational treatment is the adoption of such measures as will aid the patient to drain herself of the products of decomposition as soon as they are formed, and to institute such constitutional treatment as will enable her to throw off in due time, the dead from her living tissues.

In case of hemorrhage, the irrigation of the uterine cavity with hot water will not only check it, but prove a valuable antiseptic, antizymotic, detergent and *oxytotic* measure. For the latter effect alone it should be resorted to then, daily, until it accomplishes that for which the curette and placental forceps are designed to accomplish at one sitting, and at great risk, by reason of the *force* which must *necessarily* be employed in their use, if required at all. Nor is there any hard or fast rule by which this force can be regulated for the safety of the patient. What would be considered gentle traction by one physician would be regarded as undue violence by another.

May it not be true that something more is necessary to cause blood-poisoning than the mere absorption of decomposed placenta: that there is such a thing as benign, non-infectious, innocent or harmless putridity in the same sense in which we speak of healthy pus? Robin asserts that putrefaction destroys animal poisons and this view is sustained by a number of cases in my practice, treated since the notable one of Mrs. Ryan's in which the odor present was most intolerable, unusually disgusting, more characteristically putrescent, and yet they all recovered

their normal condition without the slightest symptom of septicæmia. This happy result may, however, be wholly due to the fact that no part of the foul drainage had been taken up by the circulation; but it is worthy of note that in the fatal cases of child-bed fever which I have seen, the fetor present was not to be compared in offensiveness with that which characterized the cases of recovery from retained placenta.

You will perceive then, gentlemen, that I have taken the assertion of Verneuil, that in the traumatic condition there is a virus formed peculiar to that condition, and the assertion of Robin, that putrefaction destroys animal poisons, and evolved from these several statements the theory which very naturally suggests itself, that child-bed fever *per se* may be due to the absorption of material *prior to the loss of its virulence by putrefaction*. I merely throw this out as an idea which occurred to me during the contemplation of the statements of these eminent men. It may be true, however, that puerperal fever is due to some *unknown* cause antecedent to but developed by the accouchement. If such be the case, that cause can only be discovered by the adoption of the practice of examining carefully and critically every pregnant woman, and repeatedly too, during the latter weeks or months of utero-gestation.

I have read somewhere an account of several cases in which the entire placenta were absorbed without producing any deleterious results whatever; but in these instances they may have remained so vascular or so vitally connected with the uterus, that they were simply removed as an ordinary deposit of lymph is absorbed, without the occurrence of the least amount of decomposition. In the OBSTETRIC GAZETTE, for March, 1883, is reported the case of the retention for forty days of a detruncated head and the placenta, the patient having recovered without a bad symptom. Dr. Valenta, the physician who first reported it to a foreign journal, being himself a foreigner, and in whose care the case finally drifted, has only been able to find in literature one case resembling this. This is recorded by Freund. In his case the detached head was retained for ten years, the uterus, as in Valenta's case, showing no disposition to expel it.

Very little is, I think, positively known of the nature of the putrid poison called sepsin, whether it is a soluble substance of chemical origin, or whether its poisonous qualities are due to those minute living organisms which are denominated bacteria.

Having written sufficiently at length to indicate the light in which we view this subject, we close its present consideration as we began, with the request that everything, pro or con, relating to it which may be known to those who chance to read this article, may be sent to us before the meeting of the Indiana State Medical Society, which takes place in May, 1883.

In response to this closing request for criticisms, I received quite a

number of letters from various parts of the country, all endorsing the position taken, a few of which I will now produce:

Dr. B. S. Woodworth, a leading physician of Fort Wayne, and a former president of this Society, thus writes:

"I heartily approve of your doctrines in these cases, having practiced them for forty-five years at least. Of course, I have had many cases of abortion, at all stages, and I cannot recall a case that did not do well, though it is possible that there may have been a few cases otherwise. I can recall a few cases that occurred within the last two years, where I had a troublesome hemorrhage to contend with for some weeks, but which finally perfectly recovered by leaving them to rest in a recumbent position and ergot. I think that in nearly all cases ergot is sufficient to accomplish a cure; although I have always had a placental forceps, I have never yet had occasion to use it. I believe there is far greater danger in attempting, in a violent manner, to remove the placenta after an abortion than allowing it to remain for nature and ergot to accomplish it. In other words, I think there is more danger of inducing metritis by instrumental interference than of septicæmia from retained placenta."

A letter received from an honored member of this Society, who also was once its President, Dr. Wilson Hobbs, of Knightstown, Indiana, contains the following sensible language:

"I have been thirty-two years in the practice of medicine and never yet removed the placenta after abortion by violence. It has been my uniform habit to leave its expulsion to the forces of nature, assisted or unassisted as each individual case prompted me, and certainly I have no cause to change my practice as I have never had such patient fail to do well. No persuasion could induce me to do otherwise than trust to nature and the fulfillment of plain indications as helps to her. With confident expectation that she would triumph at last, whether it be hours, days or weeks. In one of my cases nearly three weeks elapsed before the clearing was complete, but there was at no time signs of septicæmia. I need not argue this case before you or look into the literature of the subject; that matter you have in hand, and your plan embraces all this. The most you have to do is to show that because one woman or one hundred women have survived the procedure of tearing a placenta from them, it is not proved that they would not have been much better off left to themselves, to nature and to the care of some intelligent old woman."

Dr. H. G. Landis, professor of obstetrics in the Starling Medical College, writes as follows: "Yours of the 15th with article on the treatment of retained placenta after abortion are at hand and have been read with pleasure. Perhaps I can start the subject best by quoting—from memory—from a certain Quiz-Compend of Obstetrics, now going through the press: 'We should endeavor to remove the placenta at once after an abortion, persevering as long as we are sure that our efforts, at removal

will do less harm than allowing the placenta to remain.' Before you pronounce this too oracular, consider that it does what is very desirable, *i.e.*, leaves much to the judgment of the practitioner at the time; the judicious will do one thing and fools—something else. Further, all cases are by no means alike and much *must* be left to the judgment. Frequently a placenta can be delivered with ease if we simply let it alone for a night and a day. In other cases, the longer it is left the worse. I know of no hard and fast rule to determine which is which in a given case. In my own practice I certainly object to the placental forceps and have never used them. If compelled to select a rule (which I am not), I would say with you "better bide a wee", as it has served me well, but I am afraid to say that some of my brethren have erred when they removed at once with a curette, etc. The way I follow the quotation is practically this: that after I have failed to extract the placenta by traction with two fingers, aided by a second grip with the uterine dressing forceps, I conclude I have done enough and await the effect of uterine contractions, using injections from the beginning, and try again next morning."

In a letter received from Dr. A. L. Knight, West Columbia, W. Va., he writes as follows: "I have intended to write you ever since I saw a notice of the paper you propose to read at the next meeting of the Indiana State Medical Society. I hope for the sake of humanity your paper will receive its merited attention and be fully discussed. Wish I could be present at your meeting. I can furnish five cases in substantiation of the position you take in retained placenta. I should be pleased to have a copy of your proceedings, containing your paper and its discussion, sent per Adams Express to Middleport, Ohio, C.O.D."

Dr. T. Curtis Smith, Aurora, Indiana, writes thus: "I like your plan of treatment very well. Have treated scores of cases in a similar way. I never force the placenta away unless laying loose and engaged in the mouth of the uterus."

A letter from Dr. M. Hartwig, of Buffalo, N.Y., editor of a German medical journal, the name of which I am unable to pronounce, contains the following: "Having read this very minute your article in the Cincinnati *Lancet and Clinic*, I try to respond to your call, with the request to excuse probably numerous appearing faults against the rules of English language. I was quite forcibly struck by your observations and conclusions and do believe that you are on the right road thus far, as I share your conviction that a placenta should be left alone if you are sure that the woman was never examined or only examined with absolute care against entrance of air or septic germs. In such case the placenta will not putrefy, however long it remains in the uterus. If it bleeds slightly, leave the woman with ergot; if profusely, add injections of hot water containing two and a half to three per cent. of carbolic acid. But if the bleeding continues uncontrollable, dilate the os antiseptically,

scratch the uterus out with a blunt spoon and finish with antiseptic washing of the uterine cavity. I am entitled to the promulgation of these precepts because I have never lost a woman in premature or timely confinement when I was the only attendant from the start. But more difficult is the decision what to do if putrefaction, endometritis, metritis, general peritonitis or multiple emboli are already present when you are called. I have saved women with each and several of these conditions, but I have not always instituted the same treatment of course. * * * Here I wish only to add that whoever is fully imbued with the latest researches concerning putrefaction and Listerism will not err in these questions, but will achieve grand results. The question of putrefaction and absorption of poison, such as occurs in puerperal fever, I deem nowadays the most lucid in medicine and almost perfectly solved. Bacteria in the air produce poison in decomposing dead and to a lesser extent living tissue. You have saved your first case because meddling would have caused absorption of more poison, and with rest and quinine and antizymotic injections the body had power yet to oxidize the quantity of poison already absorbed."

Dr. Francis Wardroper, of Lexington, Kentucky, thus writes: "I am entirely in accord with your views, expressed generally to the profession, and particularly on this subject. I enclose you an account of two cases occurring in my practice in the years 1875 and 1880."

Dr. Wardroper's letter was only quite recently received, after I had this paper prepared, and I have only succeeded in sandwiching a few lines of it. In one of his cases the placenta was retained thirty-six and in the other forty-eight hours. They were not intentionally "let alone," the doctor remarks, but, he continues, it is fortunate they were not treated "secundem artem," for they could not have done better.

Dr. H. Landon, of Remington, Indiana, writes as follows: "Your article in the December 9th number of the *Lancet and Clinic* I have read with pleasure. As you request professional response I take the liberty to write you my experience, covering sixteen years of private practice. In all that time I have seen many abortions, from causes innumerable, and my management has been, whether there was hemorrhage or not, if the placenta had not been thrown off to tampon the patient solidly. After prescribing from one-half to a teaspoonful of fluid extract of ergot every four hours and a powder or two of opium for pain if needed, and enjoining perfect quiet until my return, I go about my business with perfect security. In from ten to twenty-four hours, being governed somewhat by the date of miscarriage, always visiting those soonest who abort near the fourth month, I return and remove the tampon, cleanse the parts, and if the placenta has not yet been thrown off, I tampon again as before and continue this line of procedure until it comes away. I have never yet failed with this treatment, nor had a single accident of any kind."

Prof. Palmer, of Cincinnati, thus expresses himself upon this, indeed, very practical and important subject:—"If the canal of the uterus is dilated, and the uterine contents detached, they can usually be easily removed, and should be at once. But if the canal is not dilated, the contents attached, and there is no hemorrhage—and there is not apt to be—is it prudent to permit them to remain, or is it best to proceed with their removal? Just here there is a difference of opinion. To remove the placenta, implies an artificial dilatation of the cervical canal, and the employment of more or less force in the detachment, an operation sometimes easy of accomplishing; but again, it may be difficult, attended with danger of injuring the uterus, provoking of hemorrhage and increasing the risk of septicæmia. The expectant plan, or permitting the uterus to remain undisturbed, is attended with a very slight risk of hemorrhage, and the danger of septicæmia while the placenta is attached, is inconsiderable. The former, if necessary, is easily controlled by the tampon, till detachment occurs, when all may be removed; the latter by washing out the vagina with carbolyzed water, can probably be prevented. Its possible occurrence may make it necessary to empty the uterus. Under all the circumstances it seems most prudent to take the conservative course—leave the case largely to nature. Watch for complications, meet them, until some urgency arises by a threatened or developed attack of septicæmia. It is safe to wait for the spontaneous expulsion of the decidua and early placenta, aided, it may be, by the judicious use of the tampon, rather than to forcibly empty the uterus."

Prof. Trush reports a case in which, after confinement at full time, the placenta was retained and absorbed. Dr. Illovy refers to a case reported from Liverpool where a placenta had remained in the uterus for a period of over two months, the woman all the time well and about at her household duties, until one day she was seized suddenly, with a severe hemorrhage, and to the surprise of the medical attendant, expelled a placenta. During his term of service in the Cincinnati Hospital, there came in two cases of retained placenta that had lasted for a considerable period and in which no other evils followed; they were expelled piecemeal.

In Dr. J. D. Chambers' notes on the lectures of Prof. E. S. Dunster, of Ann Arbor, I find the following:—"It is a very rare thing to save an ovum after the symptoms of abortion are well developed. May prescribe opium if the ovum is lost, and may arrest the hemorrhage by the use of the tampon. Best material for tampon an old handkerchief or sheet, torn into strips like bandages and packed first around the cervix then over the os and then fill up the whole upper portion of the vagina. Leave the patient in perfect quiet. If properly adjusted, hemorrhage ceases in half an hour. The pains may occur or recur so severe as to expel the contents of the uterus together with the tampon and other contents of the vagina. If allowed to remain remove in six or eight hours and re-

peat if necessary. *Never use an instrument to remove the placenta.* Use the fingers. *The danger in cases of retained placenta has been greatly exaggerated.* In early abortions leave it alone. If septicæmia occur it may be very easily distinguished." Dr. J. D. Chambers, himself, writes:—"It has been my rule to follow the same plan that I do in labors at full term so far as is practicable: that is, remove the placenta before leaving the patient if easily done. I never have, however, employed instruments of any kind for the removal of the placenta, nor do I favor their use. I believe more cases of septic poisoning result from injuries in using them than from retained placenta. If the uterus has the power to force from its interior, as we know it has, a body which many times taxes severely, the strength of the accoucheur with instruments to remove—a child at full term—I believe it also has the power to expel the soft, easily moulded placenta, and I have far more confidence in the ability of Nature to effect safe, complete, and sufficiently speedy expulsion of the after-birth, than I have in the blind groping with instruments held by inexperienced hands, in a dark cavity, after a soft, yielding substance, surrounded by other soft, yielding substances which, if injured, endangers the setting up of the very conflagration we are seeking to avoid."

Miles F. Porter, A.M., M.D., Professor of Anatomy in the Medical College of Fort Wayne, thus writes;—"I have never thought it necessary to use the placental forceps. My practice has been to allow the placenta to be expelled by the natural forces, aided at times, it may have been, by ergot, hot or cold injections, etc. The only indications for the forcible removal of the secundines in my opinion, are hemorrhage which cannot be controlled by hot or cold injections, ergot, etc., and a fetid discharge with symptoms of blood infection. I have met with a *few* cases in which each of the above emergencies existed (I think they rarely occur with proper care), in which I removed the placenta with my finger. Where a placenta is not expelled with or soon after the foetus, my habit is to give ergot or opium as indicated, together with hot water injections; and where it is retained beyond six or ten hours, I order the water carbolized with a view of preventing septic infection. I have always pursued the course I have here indicated and as yet have no cause to regret it. I allow the placenta to remain rather than remove it by force, because, while it is adherent, there is no danger of its becoming putrid, and hence, a source of infection, and after its attachments are broken up by natural forces the same are sufficient to expel it; if not, the only aid needed is that furnished by a proper use of the finger. By forcibly removing it we open new avenues for the ingress of morbid matter and, in the majority of cases, leave a certain amount of partially detached pieces which are likely to decompose and enter the avenues already opened for them."

Now, gentlemen, I have given you my views upon this question, and,

in support thereof, those of a number of my brethren who have responded to my request for an expression of their own. There are, however, to this, as to all questions, two sides, and no paper deserves the title "scientific" which does not deal honestly with opposing facts, in order that truth may be elicited and science advanced.

The champion of the immediate, forcible removal of the secundines after abortion, in this country, is Dr. Paul F. Mundé, inventor of a curette and forceps for this purpose, editor of the *American Journal of Obstetrics*, and author of a valuable work on Minor Surgical Gynecology. In his journal for February of the present year, appear two papers upon the subject now under notice, one by himself and the other by Dr. T. J. Alloway, of Montreal. I would be glad to reproduce these papers in full in order to render my own as exhaustive as possible, but forbear lest I become wearisome. Both cite a number of cases in sustentation of their position, but the question still remains whether or not those cases would have recovered as readily under other and milder treatment. Dr. Mundé produces a table of 57 cases, collected during a period of fourteen years, of which number 27 occurred in his own practice, and thirty were cases in which he was called in consultation. In fifty-two of them the symptom calling for removal, was hemorrhage, which fact sustains the opinion I have expressed in the former part of this paper, that "the danger of blood-poisoning in these cases, is, *as a rule*, more apparent than real." In five of his cases *only*, was there any evidence of septic infection. Of the whole number there occurred one death from septicæmia, which disease, he remarks, was present when he operated, and one case in which the operation was followed by cellulitis. He closes his paper with the observation that "If figures carry any weight with them and prove anything, there can be no question that these fifty-seven cases of mine prove the safety and utility of the *forcible* removal of the secundines." It will be noticed, however, by the quotations which follow, that Dr. Mundé's use of the word "force" is characterized by no little ambiguity; or, in other words, that he advises the "*forcible*" removal of the secundines *without any force*.

Dr. Mundé thus writes:—"But I wish to add my testimony to that of Dr. Alloway, as given in his paper in the present number, *in favor of the forcible* (that is, manual or instrumental) removal of the secundines immediately after the expulsion of the foetus, in every case where the cervical canal is sufficiently patulous to permit the introduction of the finger or of the large dull curette or the placenta forceps. Further, if there is hemorrhage, or an offensive discharge, or if the temperature rises, or there is a chill, and the secundines are still retained, no matter how soon or how late after the expulsion of the foetus, they should be at once removed, and, if necessary, the cervix dilated to facilitate the operation.

* * * * I have noticed that, with rare exceptions, authors ad-

wise the active policy recommended by me, particularly those whom their special practice has made adepts in uterine manipulations. * * * * The future safety of the patient demands that the secundines should be *at once* removed after expulsion of the foetus in every case of abortion in which such removal can be accomplished *without force sufficient to injure the woman*. * * * * Now, the questions will very properly be asked, is all this manipulation so free from danger that every physician can employ it, and is not the risk from the *forcible* removal of the secundines greater than that possibly incurred by letting them alone? I answer most emphatically to the first, yes; and to the second, no. It is true that the more experienced the practitioner is in gynecological manipulations, the easier and safer is this operation. But even the most inexperienced physician can perform it with impunity, both by the fingers alone and with the dull curette, *if he but remembers that "FORCE" should be absolutely avoided*. Dr. Alloway quotes Dr. Mundé as having said also, that "If the placenta can be removed without undue violence, either by means of the fingers or some instrument, it should be *at once* removed."

To recapitulate, then, Dr. Mundé starts out very vigorously and emphatically, in italicized language, "in favor of the *forcible* removal of the secundines" and, if necessary, "a *forcible* dilation of the cervix to that end." In a subsequent declaration, however, he loses some of his original vigor and emphasis, in the statement that "the future safety of the patient demands that the secundines should be at once removed after the expulsion of the foetus in every case of abortion *in which such removal can be accomplished WITHOUT FORCE sufficient to injure the woman*." But he immediately counteracts the "force" of this qualification by the following questions which he asks and answers: "Is all this manipulation so free from danger that every physician can employ it? I answer most emphatically, yes. Is not the risk from the forcible removal of the secundines greater than that possibly incurred by letting them alone? I answer most emphatically, no."

Following immediately upon these emphatic answers is still another statement of doubtful significance: "But even the most inexperienced physician can perform it with impunity, *if he but remembers that "FORCE"—exactly what, in his emphatic answer, he said could be used without greater risk—should be absolutely avoided*."

And now, as a fitting close to the foregoing quotations of uncertain sound, comes the impossible "if". "If the placenta can be removed without undue violence, etc., it should be at once removed."

You have heard that Dr. Mundé has said that "all this manipulation is so free from danger that even the most inexperienced physician can employ it." I will now quote from his *Minor Surgical Gynecology*, pages 280, 285, 286:—

"There are four varieties of curettes in present use. Of these, each

has its special indications and dangers. If the uterine mucous membrane is healthy the wire curette will not injure it, and no shreds will therefore be removed; with the sharp curette, however, even the most delicate and practiced hand can scarcely avoid shaving off slices here and there, the depth of which lesions cannot always be foreseen. I decidedly prefer the dull curette as more safe than the subacute, while quite as efficient. Récamier himself met with three cases of death from perforation of the uterus by his curette; Demarquay with two; Chamberlain, of New York, saw a case of hysterical tetanus therefrom; Peaslee, a death from collapse; Thomas, a narrow escape from the same cause, and Barker, a case of peritonitis." How wonderfully riskless then, is this manipulation? "Even the most inexperienced physician can perform it with impunity."

None but thoroughly experienced practitioners, says Tilt, should venture on the surgical treatment of the internal surface of the womb, and he looks upon the American idea of instantaneous dilation as audacious. Even when there were no long-standing pelvic lesions, careful operators like Huguier, N. Guéne de Mussy, Broca and Sirédey have seen the use of the uterine sound followed by speedy death. Hodge, Willard, Wilson, Simpson, Meadows and Duncan, continues Tilt, all report cases of death and dangers resulting from forcible dilatation. Dr. Thomas reported a case in which the introduction of three of Peaslee's dilators were followed by fatal peritonitis.

In the Cincinnati OBSTETRIC GAZETTE for March of the present year, Prof. Reamy is reported to have said in a certain discussion:—"I have been in the habit of using the blunt curette in my office with no accidents following, but most positively have not done so in the last two years: would consider myself guilty of criminal blundering to do so now. I never use it without ordering the patient to bed. I have now abandoned what I had formerly practiced, viz: the use of the curette immediately upon removal of tents. Still more, would I not think of it within a few days thereafter."

Prof. Palmer, who participated in the same discussion, said:—"I once encountered a most profuse hemorrhage while curetting the uterus for a lingering muco-sanguineous discharge after an abortion. The tendency of accumulating gynecological experiences is to make one more and more cautious; to make one sometimes refrain from doing now that which at one time he regarded as judicious and safe. It is the commonest thing to find peritoneal adhesions within the pelvis of women dying from non-pelvic causes after the age of 30 or 35 years. A mild pelvic peritonitis, so mild that it has escaped notice, or its symptoms been forgotten, is very frequent."

And now, in conclusion, gentlemen, I have no doubt that many of those instances of suspected retained placenta, diagnosed particularly on account of more or less continued hemorrhage, are, in reality, cases of

mere subinvolution, which would respond to quinine, tincture of iron and ergot, or to the introduction into the cervix of a catheter and the injection through it into the uterine cavity, of hot water, medicated or not, as may be preferred. Tilt believes that all the deaths caused by intra-uterine injections occurred before the recognition of the importance of full cervical dilation, and asserts that in most of the fatal cases, a solution of nitrate of silver was used.

Even though pieces of placenta should be retained, an intra-uterine injection would not infrequently excite sufficient contraction to effects their detachment and removal, as readily as by repeated syringing with warm water we never fail to remove those tenacious plugs of wax from the ear. This procedure would, it seems to me, be far less dangerous than that taught by Drs. Mundé and Alloway, and tend to prevent the young practitioners of the day from becoming in the near future, a generation of fashionable womb-scrapers. The organ which God Almighty created especially for the propagation of the human race, is, if one may judge from its modern torture, a total failure; hardly adequate to the designs for which it was constructed.

We have not yet divested the profession of that peculiar mysterious or artful complexity which has ever marked its history. There is still a great tendency to render the treatment of the most simple and natural ailments, difficult and complex, and to represent as pathological, many physiological processes. We have an idea to be "scientific" a physician must be almost if not entirely incomprehensible. We lose sight of the fact that the higher we ascend the scale of wisdom the closer we hug the dust.

The grand results of scientific research are not obtained alone from dreamy flights into the region of the unknown, of mere theory and unmeaning technicality, and the millenium of medicine will never come until words of modest proportions shall constitute her phraseology.

We are too prone to attempt first the investigation of the huge boulders of the occult and the mysterious rather than become familiar with the pebbles of simplicity which lie at our feet. He is the most successful physician who is the most natural. The wisest men of every age were grandly simple. Christ Himself, the Great Physician, made use of the very simplest things in nature to illustrate the most momentous truths. Nature is our standard and should ever be borne aloft. Simplicity should be the watchword of the profession. Huxley does not consider it beneath his dignity as a scientist, to lecture on yeast; nor does Tyndall, on water; Mivart, on the frog; Darwin, on the caterpillar. These advance thinkers, by humbling, have exalted science, and carved for themselves so lofty a niche in the temple of honest fame, that their memory will remain embalmed in the grateful hearts, and their deeds be sung in the loud acclaim of generations yet unborn.

EXTIRPATION OF THE UTERUS.

By O. E. HERRICK, M.D., Grand Rapids, Michigan.

This operation has been quite frequently made within the last two years both in this and foreign countries, and the results obtained thus far have not been such as to popularize it to any great extent either with the general profession or the more conservative of gynecologists. The very nature of the operation makes it even more distasteful and formidable to the operator, who regards his patient in the light of a human being instead of mere material for scientific experiment than its twin sister oophorectomy; from which operation it seems to have suddenly received its present resurrection and impetus. Unlike the latter, far more cases result fatally than recover, and there are many less conditions of disease and abnormality calling for an operation that is at once revolting to the operators sense of humanity and terror inciting to the person to be operated upon. Removal of the uterus by the knife is an operation that was practiced by the ancients and abandoned on account of its fatality, barrenness of good results and barbarousness, long, long ago; and that it should be revived now except for malignant disease, or when made necessary during abdominal section to save a life otherwise sure to be lost, is to my mind a reproach upon modern surgery. These remarks have been suggested by reading an article in the "American Medical Digest" for Jan. in which is reported an operation for extirpation of the uterus, for prolapsus, by Dr. A. Martin of Berlin. It is a fortunate circumstance for American gynecologists that the operation was performed in Germany, for we are now accused sufficiently of making reckless and unwarranted operations without the addition of this one, and besides, I am sure that no woman in America could have survived what Dr. Martins patient did, and he states in his report that "the patient eventually recovered", and that too, after he had subjected her to operations for amputation of the cervix, two anterior and posterior kolporrhaphy perineorrhaphy and subsequent to the removal of the uterus, another anterior and posterior kolporrhaphy; then he states "the patient was beleived to be entirely cured", of what? A *prolapsed uterus*, I should think so! great shades of Celons! but this German is phlegmatic with a vengeance, he *believes* the "patient to be entirely cured", after all these operations, among them removal of the uterus, but does not *certainly* know. If I did not follow gynecology as a specialty myself, I might be uncharitable enough to suggest that perhaps after all the woman might possibly be dead. But seriously, [and to me this is a very serious matter] it seems almost incredible that any one, and epecially a great gynecologist, should extirpate the uterus for prolapse, and surely no one but a great gynecologist with his reputation made, and past the possibility of having it pulled down, could make such an operation, and escape criminal prosecution. To my mind

an operation for closing the vagina would be much more warrantable after all ordinary measures had failed, and there is no case of prolapse so *bad* that it cannot be at least controled by a proper fitting pessary or supporter, as a rule the patient can be made comfortable if not entirely cured, by such means; in point of fact, prolapse of the uterus is the simplest form of uterine displacement, and the most easily controled by mechanical supports, a tampon of cotton or a sponge held in the vagina by a perineal bandage, would be thought of by the medical attendant in this country, before he subjected his patient to extirpation of the uterus. It is such operations that bring discredit upon gynecology and gives the enemies to specialism in medicine a weapon to attack, and more or less retard, a branch of scientific investigation and growth that if kept within its proper channels, would do more towards making medicine a rational science than any other one line of research. Medicine in the future as in the past can only advance by patient individual effort confined to one of its numerous branches at a time. For this reason, if for no other, professed leaders of the specialty of gynecology, should abstain from reckless operations; and personal ambition should not weigh against the needless putting in jeopardy of a human life, I fully reconize the frequent necessity, in gynecology, as in no other specialty of medicine, of making severe and sometimes formidable operations to save life, but it behooves us as members of a comparatively young speciality not to make such operations for trifling causes. American gynecologists have been charged with making too many operations, but they as a whole are much more conservative than the English, French, or German. The Americans may make more plastic and small operations, but the foreigners take the lead in capital operations, and while some of the more important ones were first made in this country, they have been taken up abroad, and made upon the poor peasant women by the hundreds and thousands; an American gynecologist who reports twenty or thirty operations of a given kind, is thought to have gained unusual distinction, but the operator in the fatherland who cannot count in support of his pet operation, at least one hundred cases, is not thought to have experience enough to warrant him the attention of his colleagues, or to give his utterances a greater weight than those of the mere beginner in experimental surgery. Take for instance oophorectomy first performed by Dr. Battey and an operation made comparatively seldom in this country considering the fact that it is an American operation; out of the large number of gynecologists here, not one half of them have ever made the operation, and the few who have, have only made it from one to a dozen times each, showing that the cases must have been carefully selected, and the operators extremely cautious about making it except for well defined indications. Not so with foreign gynecologists, for they have taken up the new operation, and performed it by the hundreds if not thousands of times in both their private and public hospi-

tals and cliniques. Whenever an American gynecologist goes over there, they are ready to give an exhibition upon a moments notice, never lacking for the material to give the exhibition upon, in reading the reports of these exhibition operations one is strikingly reminded of the professors of Physiology in our colleges, who send out to the college *dog kennel* for a fresh *dog* with which to illustrate each of the phenomena of animal physiology. And what is true of this operation is true of all new and formidable operations such as extirpation of the uterus, ovariectomy, Porro's operation etc. They are not quite so ready to take up the smaller operations, some of which are of inestimable value in controlling and relieving diseases and conditions hitherto but little understood, as for instance Emmets operation which has been poohed at considerably by our English cousins; the game seems to be too small for them, but when it comes to excision of the stomach or extirpation of the uterus, they seem to be ready to go in and roll up for our inspection a few hundred cases. It seems to me, that if we all give a little less attention to operative gynecology and more study to the relationship between the sexual organs and the frequent anomaly of the nervous system and kindred subjects, gynecological art would go forward with surer if not longer strides.

Reports of Societies.

TRANSACTIONS OF THE OBSTETRICAL SOCIETY OF CINCINNATI.

Stated Meeting, April 12, 1883.

The President, DR. J. TRUSH, in the chair.

Dr. Wenning read the following paper on

HYPERTROPHY OF THE LABIA MINORA.

On the night of November 5th, 1883, I was called to see Mrs. K. G. aged 26, American, married, of spare build, light complexion and a nervous temperament. According to her statement she was at the time in the sixth month of pregnancy. She had been in good health, excepting a complication presently to be described, went to bed as usual, but got up during the night as she supposed in a dream, walked to an adjoining room where she stumbled and fell, awakening thereby her husband. It was feared that she had injured herself and as there had been some hemorrhage from the womb I was summoned. I found her still in a state of great excitement, but was told that the hemorrhage which had amounted to but very little had ceased. Nevertheless I requested permission to make a vaginal examination which was at first refused on

the plea that it was unnecessary. I however, insisted upon the necessity of making an examination and proceeded to do so when the woman restrained me by saying that there was something wrong about her; a midwife had told her in a previous confinement that her womb was out of place. This naturally enough still more excited my curiosity and I pressed my determination, until finally permission was reluctantly granted.

As soon as my fingers came in contact with the external genitals they struck upon a large tumor, lying directly in front and completely covering the vulvar opening. It was a pear-shaped body, soft and elastic to the touch, but movable. It had the feeling of a fatty tumor arising from the clitoris or some point near it, and extending along the left side of the vulva. As the tumor was movable I could lift it upwards out of the way over the left groin, when my finger passed readily into the vagina and to the os uteri which was almost beyond reach and slightly patulous. There was no further cause for alarm as the hemorrhage had ceased, and I contented myself with prescribing a few powders containing gallic acid and left with the promise that I would call again the next morning.

My interest had been wholly aroused by the presence of the tumor and I intended at my next visit to make a more thorough examination, which was precluded at my first visit on account of insufficient light and the excitement of the patient. When I called the next day, the patient was up and in ordinary health, complaining of nothing but a sense of weight in the lower part of the abdomen and a severe cough with which she had been troubled for some time. When I endeavored again to make an examination, the lady declined and seemed to regret that I had obtained any knowledge of her true condition, which she had hitherto successfully concealed from any other medical person by calling in a midwife to attend her in her second confinement, instead of a physician, as in her first. She gave as a reason, that she feared to be operated upon. As I was satisfied from the position of the tumor that it would in no way interfere with her forthcoming delivery, and as I did not care to incur the risk of a miscarriage, consequent upon an operation which could well be deferred till after the natural term of labor, I gave the patient the assurance that nothing of an operative kind should be done, but exhorted her in the strongest terms at my command to submit to an operation before her next pregnancy, as the growth might afterwards interfere with parturition.

I then obtained the following history, deferring a closer examination till some future time.

Mrs. K. G. was married about eight years, during which she gave birth to one child, which was now six years of age, and in good health; a second child was born dead in the seventh month of gestation, and she was now carrying her third. Menstruation had always been regular

before and after marriage. Her health had always been good before marriage, and in the first few years afterwards, until the tumor began to make its appearance, five years ago. She first noticed a small growth, the size of a walnut, but soft and painless, situated just below the mons veneris. It appeared to come on without any evident cause; she had sustained no injury, had had no sore of any kind in these parts, and had had no vaginal discharge.

She experienced no pain in micturition or at sexual intercourse at this time. Two years later she gave birth to a dead child at the seventh month without any difficulty, although the tumor was then half of the present size. After this the woman again menstruated regularly until she became pregnant for the third time. The tumor in the meanwhile continued to grow, but with greatest rapidity during pregnancy.

Her condition now was one of great discomfort, great inconvenience in walking being caused by the weight and tension of the tumor. In order to obtain some relief, she was compelled to construct a bandage provided with an opening, through which the tumor was drawn upwards to the left of the pubes, and thus supported.

Further particulars as regards personal or family history were of a negative character, and I simply treated the patient with tonics and expectorants for her harassing, obstinate cough, and was engaged to deliver her at the forthcoming labor, which was expected towards the end of January or beginning of February.

On the 18th day of December I was again suddenly summoned to this patient when I found her in active labor pains. I delivered her of a dead foetus, foot presentation, without much difficulty, but had some trouble in removing the placenta, which was firmly attached to the walls of the uterus. The foetus had the appearance of having been dead for at least three or four weeks as there was considerable desquamation of the cuticle and discoloration; but it was of about normal size. The placenta showed nothing abnormal as far as macroscopical examination could determine.

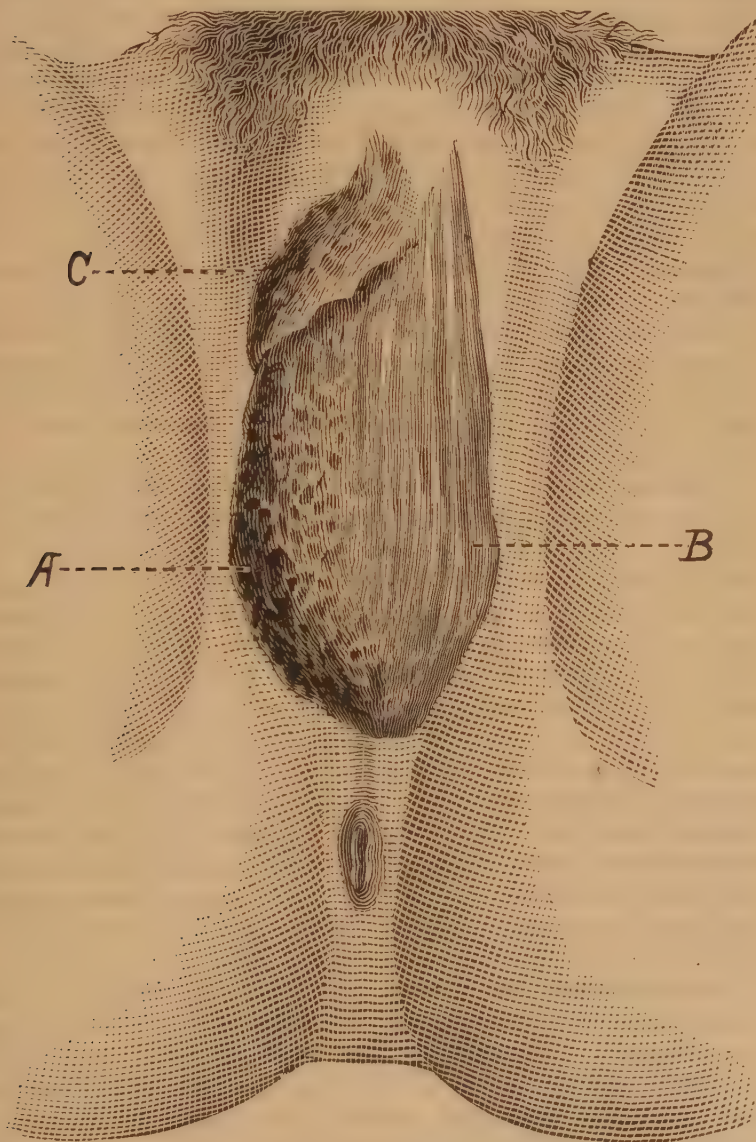
The mother had considerable fever for a few days, which was controlled with large doses of quinia and the constant use of carbolic injections into the vagina.

From this time on, the patient made a rapid recovery, and I obtained her consent to remove the tumor at the earliest practicable period. In the meantime she was removed to a better habitation, placed under tonic treatment, and all preparations made for removing the tumor by an operation.

I then had an opportunity for the first time of making a thorough ocular examination: When the patient lay in the ordinary position upon her back the pear-shaped mass hung down centrally over the vulvar opening, as if it were an enlarged clitoris. When the thighs were com-

pletely abducted another smaller tumor, which had been covered by the larger, was brought to view attached to the right side of the vulva.

The larger tumor was of a dull red color, and covered with warty excrescences in front and on its right side, which was thicker, whilst the



EXPLANATION.—Appearance of the two tumors with the thighs extremely abducted. A, the warty surface of the larger tumor. B, the smooth surface of the same. C, the smaller growth brought to view by separating the limbs.

left side was smooth and of a striated appearance. It was soft and elastic to the touch, not very tender except on very firm pressure. Its attachment began immediately to the left of the clitoris extending in a somewhat curvilinear direction for the distance of about two and one-half inches along the left side of the vulva just beneath the labium majus—which was smaller than normal—and extended to a point midway to the ostium vagina. The tumor was continuous with and formed part of the left nympha. As stated before, it was movable upwards and outwards like a leaf, owing to its wide, but thin attachment. Its dimensions were as follows: length from the highest point of attachment to the most dependent point, $4\frac{1}{2}$ inches; width at its widest part, $2\frac{1}{2}$ inches; thickness at its thickest portion (antero-posteriorly), $2\frac{1}{2}$ inches.

The smaller right tumor, was auricular in shape, and also formed a part of the upper portion of the right nympha, but was wider in its attachment than the larger growth. Its width was about two inches.

The accompanying sketch which was made by my friend, Dr. Geo. E. Jones, whilst the patient was in the lithotomy position, just before the operation, gives a correct view of the appearance of the tumor at that time. The dark points on the left side represent the warty excrescences as they stood out prominently. (See explanation of cut).

Accordingly, on January 23d, 1883, the patient was placed under ether and with the assistance of Drs. Jones, Cleveland, and Walton, I removed the tumors with the curved scissors. Considerable hemorrhage followed, but was soon controlled by hot water. Two condylomata, one on the anterior and the other on the posterior wall of the vagina, were ligated and left to themselves. They came away in about four or five days. A cotton compress soaked in a solution of carbolic acid was then placed over the denuded parts and the patient put in bed. At my next visit, three or four hours after the operation, the patient was bleeding profusely and had continued so for some time, having been for some inexcusable reason left alone. I found her blanched and very weak from the loss of blood. I administered stimulants freely and controlled the hemorrhage as no bleeding vessel could be found, by a very firm compress by means of the T bandage. The wounds were then dressed with boracic acid, first in powder and afterwards in solution, and were completely healed before the end of two weeks.

Although all endeavors to obtain from the patient a clue as to a specific cause of this tumor proved negative, the history of two miscarriages and the presence of the condylomata were suspicious elements as regards syphilitic or at least venereal infection. I therefore closely interrogated the husband, who told me that five or six years before marriage he had contracted a soft chancre on the prepuce, which, however, after being cauterized with nitric acid, healed in a few days and gave him no further trouble afterwards. Since marriage he declares never to have indulged

in promiscuous intercourse, nor to have been troubled with any venereal affection. The first born child, a girl, now about six years old is apparently in most excellent health. With a view of obtaining some further information from a microscopical examination, I sent the specimen to Dr. F. Kebler, who declared it to be "a case of simple hypertrophy and nothing else". As to the cause, he thought, the clinical history of the case would tell better than a microscopical examination.

The etiology of this affection is undoubtedly the most interesting feature. Was this a syphilitic growth, a simple hypertrophy, or was it an elephantiasis, a form which is described by some writers under the term *elephantiasis mollis*? The presence of condylomata in the wife and the history of a soft chancre in the husband lend support to the view that the larger growths were of a specific nature. But if we may believe the patient that she suffered from no trouble of any kind previous to and even after the development of the tumor, and gave birth to a living and healthy child in the first years of her marriage an infection at this time does not seem probable. On the other hand, the history of two miscarriages subsequently, occurring both at about the same period of gestation, during the growth of the tumor, are indicative of syphilis. The husband is, however, most emphatic in his declaration that he was never afflicted with any venereal trouble except a soft chancre six years before marriage. The sore readily healed and left no secondary manifestations. Moreover, if we accept the dualistic theory of syphilis, a soft sore is non-syphilitic. Most authors also agree that condylomata are not necessarily evidences of syphilitic infection; they may arise from any source of irritation, as excessive sexual indulgence and even masturbation, although the most common cause is supposed to be a local infection from some virulent secretion in the male as, for example, an old gleet discharge. These same causes are, however, also enumerated in the etiology of elephantiasis. The rarity of the latter in this climate, the simultaneous implication of other portions of the genital organs, the characteristic density and firmness of structure and, lastly, the fact that of all the different portions of the external genitals the labia minora by themselves are at least frequently the seat of disease—Mayer⁽¹⁾ records but five in an analysis of forty-six cases—would exclude elephantiasis in a case of this kind. That most gynecologists take this view is evident from the silence on this point of some of our best writers on diseases of women whilst others barely mention the occurrence as a great rarity frequently relying solely on the testimony of others. Thus Kiwisch⁽²⁾ aside of those observed by other authors whom he cites, mentions one case occurring in his own practice, and Scanzoni in treating of the subject also says that he saw but one which occurred in the practice of Kiwisch and is the same case referred to by the latter. L. Mayer, who has written most extensively on the subject in an article published in the "*Berliner Beiträge zur*

Geburtshülfe und Gynäcologie," vol. I, considers elephantiasis of the vulva a most frequent affection even in the more temperate zones, and avers that the little inconvenience that it gives to many women prevents them from seeking medical advice. He also gives the history of ten cases occurring in his own practice and extending over an experience of fifteen years with illustrations of all the different varieties. Mayer says among the exciting causes of elephantiasis syphilis takes the first rank, next masturbation or excessive venery, and finally mechanical injury. In the latter certainly a dermatitis must be the precursor of any subsequent stationary enlargement, a symptom which is certainly absent in many cases and was also wanting in the subject of this sketch. The most common but also most obscure of all causes, a cold, is even said to be sometimes a factor in this affection.

As the etiology cannot establish a diagnosis let us briefly consider what pathology may offer in this respect. Elephantiasis is defined by pathological anatomists as a "hypertrophy of the cutis and subcutaneous cellular tissue, in which the epidermis may or may not be involved." The term elephantiasis as is well known, is derived from the elephantine proportions assumed by the enlarged leg in the tropical and subtropical climes where this disease is endemic—known also by the name of Barbadoes leg. The frequency of a similar occurrence in the scrotum of the male and the labia of the female in the same climate, with or without the simultaneous concurrence of the disease in the lower extremities has led to the adoption of the same word for excessive hypertrophy of these parts. If we then restrict the name of this disease simply to those cases associated with a dense thickening of the skin and hypertrophy of the subcutaneous cellular tissue, elephantiasis is a rare affection, but if we class under its head every form of hypertrophy, syphilitic or otherwise, it is certainly not an uncommon disease.

Whilst therefore elephantiasis, analogous to pachydermia, is usually described as being of firm consistence, just the reverse, a soft variety, called *elephantiasis mollis*, occurs pre-eminently in the sexual organs. Virchow describes it as consisting of a loose (meshy) connective tissue freely infiltrated with fluid and of elastic consistence. Mayer's cases all belonged to this category and he adds that the majority of those of other observers collected by him were of the same kind.

Rokitansky⁽³⁾ in speaking of elephantiasis says, "the surface of the hypertrophied parts is smooth, more frequently, on account of the proliferation of the epidermis, rough, generally lobular, uneven and warty, coarsely or finely grained. In these cases the growth is of a papillary nature and is identical with the condyloma." Further on when speaking of condyloma he says, "condylomata or papillary growths occasionally obtain an enormous size in the form described above," referring to his previous remarks on elephantiasis.

Forster also includes these extremely hypertrophied growths under elephantiasis.

It may not be amiss to cite in this place the opinion of some of the most noted gynecologists. Kiwisch⁽⁴⁾ has the following: "Their anatomical character and even the outward appearance of some cases of elephantiasis are very much like the colossal condylomatous growths described above; besides three of the cases of elephantiasis that came under our notice occurred in individuals who were given to a life of debauchery, so that a repeated infection was placed almost beyond a doubt. Schröder⁽⁵⁾ has the following, "extensive papillary growths, so-called sharp condylomata, are caused by the irritant action of gonorrhœal virus, but according to Thibierge, may arise independently of gonorrhœa. Sharp condylomata may obtain a great size and form such immense tumors that they closely resemble the papillary form of elephantiasis. Gascoyen saw one of the size of an infant's head."

In speaking of the diagnosis, Hildebrandt⁽⁶⁾ says, "a difficulty can arise only in the epidermoidal form, when it closely resembles condylomatous growths—but a confusion of one with the other may be avoided by examining carefully the seat of the growth; elephantiasis never occurs without a simultaneous implication of the base of the tumor, whilst condylomata always have a soft, non-hypertrophied bottom."

English writers evidently restrict the term elephantiasis to the definition first given, for Barnes and West and others make no mention of elephantiasis.

Barnes⁽⁷⁾ speaks simply of warty (syphilitic) excrescences; "considerable hypertrophy of the nympha, clitoris, or more rarely of the labia majora, is not infrequently associated with these warty excrescences, a circumstance which, McClintock suggests, strengthens their probability of being due to some venereal taint. But (he continues) these enlargements frequently occur where there are no warts, and they may unquestionably occur where there is no syphilitic taint." (The drawing taken from McClintock illustrated in Barnes is similar to the sketch here presented. It also occurred in the left nympha, and is described by him as a syphilitic hypertrophy of the left nympha.)

I have bestowed so much attention upon this point to show that whatever may be the pathological difference as determined by the microscope, clinically it makes no difference whether we call these growths simple hypertrophy or elephantiasis.

The prognosis is of course, as far as life is concerned, favorable. Death cannot occur from the growth itself although it may perhaps undermine the general health. As regards recurrence the prognosis is not always so favorable, as condylomatous growths are said to be apt to reform after extirpation.

The treatment when the tumors attain such immense size can be only operative. Constitutional treatment may be serviceable in specific cases, but local applications in the form of powders etc., are only palliative; the first indication is complete removal. This may be done, first, by simple ligature, strangulating the tumor until it falls off, but which is very tedious and painful; secondly, removal by means of the scissors or knife conjointly with the ligature or without it. Previous ligature is recommended in those cases where hemorrhage is to be feared. To prevent the latter also some caustic substance or the actual cautery may be employed immediately after the division of the growth; where syphilis is suspected this is especially indicated. The galvano-cautery has also been used for the same purpose. Finally the *ecraseur* has been recommended.

That a troublesome hemorrhage may sometimes occur is evident from the case just reported. I regretted not having used the ligature or actual cautery, especially the latter as I intended. The absence of hemorrhage immediately after the operation and the apparent complete removal of all of the diseased portion, also being actuated by the advice of one of the gentleman present who thought nothing further necessary, induced me to rely simply upon the hemostatic property of the compress. If I should be called upon to remove a similar growth again I would either ligate it—if the attachment were small—previous to the removal by the knife, or unite the edges of the wound subsequently, or, finally, use the actual cautery, either in the shape of the hot iron or Paquelin's thermo-cautery.

LITERATURE.

1. L. Mayer, "*Die Elephantiasis (Arabum) Vulva.*—*Beiträge zur Geburtshilfe und Gynacologie*, Band i, 1872. The following is a condensed table from this author of forty-six cases, ten of which were his own:

Whole vulva -	-	-	-	-	-	-	3
One or both labia majora	-	-	-	-	-	-	20
" " " minora	-	-	-	-	-	-	5
Clitoris	-	-	-	-	-	-	7
Labia majora and minora	-	-	-	-	-	-	2
" " clitoris	-	-	-	-	-	-	2
Labia minora	"	"	-	-	-	-	7—46

It will be observed that the labia majora were implicated altogether in twenty-seven instances, the labia minora seventeen, and the clitoris twelve times.

2. Franz A. Kiwisch, *Klinische Vorträge*, etc., ii. Band, p. 509.

3. Carl Rokitsky, *Lehrbuch der Pathol. Anatomie*, iii. Band, p. 521.

4. loco citat. p. 510.

5. Carl Schröder, *Die Krankheiten der Weibl. Sexualorgane*.

6. H. Hildebrandt, *Die Krankheiten der Aeusseren Weibl. Genitalien*, p. 40.

7. Robert Barnes, *Medical and Surgical Diseases of Women*, p. 762. According to this author's statement the frequency of occurrence in the different parts of the vulva between simple hypertrophy and elephantiasis is just reversed, for while in the former the nymphæ are placed in the first and the labia majora in the last order, in elephantiasis the labia majora are by far the most common seat of the disease (43.5 per cent. according to Mayer), the clitoris next, and the nymphæ last in order.

DISCUSSION.

Dr. Cleveland said he was present at the operation and examined the case. The growth was deceptive in appearance as to its attachment. This is well shown by the drawing made by *Dr. Jones*. It seemed to be an hypertrophied clitoris, and such was the opinion of the essayist until he made a closer examination. The diagnosis, whether we call it hypertrophy or elephantiasis, does not appear to be of any clinical importance; whether we call it the one or the other depends upon our interpretation of the terms hypertrophy and elephantiasis. The etiology, however, is important as bearing upon the treatment and proper direction of the case. The history of the case, so far as it gives any positive pointer, is very unsatisfactory. But some parts brought out in the report of the case enable us to come to a conclusion as to what is the probable cause of this condition. In the first place, the husband had a soft chancre some years ago, before he was married, and he claims he has never had any secondary manifestations. The fact that a chancre is called soft is no positive evidence that it is a local sore; infecting chancres are not always by any means characterized by the indurated base; and there are few men so bold, or I should perhaps say reckless, as to say that a given soft chancre is a local sore. It was stated in the history that the first child born is healthy. This is apparently a stumbling block to the theory of specificity. But then syphilis is most irregular in its action and we do not yet understand its laws. The simple statement of the man that he has never had secondary manifestations does not carry much weight, for often the secondary symptoms are so slight that they might easily escape notice. The most convincing evidence of the specific nature of the growth is the two miscarriages. There were also condylomata at the mouth of the vagina. It is well known how frequently syphilis causes premature births. This fact is so well recognized that when we have premature labor with fetus dead we suspicion syphilis, even though there is no history of the disease. The evidence seems to point to the case reported as being syphilitic hypertrophy of the labia minora.

Dr. Wright said these cases were generally considered as simply cases of hypertrophy, rather than cases of elephantiasis, the pathological conditions being different. The case reported was certainly a very interesting one, but had the author of the paper read an article in a recent number of (I think) the *Obstetrical Journal*, *Mundé's*, upon Hypertrophy of the Labia, he would have noticed a similarity of cases in some of the essential features.

The results of the operation were in transfixing the enlargement with needles and ligature, thereby dividing them into segments, and then removing by the scissors or cautery knife. The scissors, I think, being more preferable, and if necessary applying the actual cautery to the surface.

Dr. Reamy said there is a great diversity of opinion as to the pathology of this disease. True elephantiasis involves a disease of the lymphatics as well as a hypertrophy of the subcutaneous cellular tissue.

Nothing very definite as to the etiology of the disease has yet been proven. The most interesting question in this connection is that of obscure syphilitic symptoms.

He had recently seen a case of hypertrophy about the meatus urinarius with condylomata around the anus in a woman. The husband had had syphilis twelve years previous. At the time *Dr. Reamy* saw her the husband had been dead five years. The disease in question making its appearance for the first time soon after his death.

Syphilis manifests itself in such a diversity of ways and at such remote periods from the time of infection that the history of any case wherein it is possible for this disease to be a factor is to be received with caution.

The case reported this evening he believed to be one of syphilitic elephantiasis. Elephantiasis is usually spoken of as a very rare disease. From the number of cases that had been operated on in this vicinity the past year, both in his own practice and that of his colleagues, he has been led to believe it of more frequent occurrence than has been formerly believed.

The removal of these tumors, he thought, was effected more readily and with less risk of hemorrhage by the galvano-cautery or thermo-cautery.

He recalled two cases, one at the Good Samaritan Hospital, the other in an adjoining city, in both of which the blood vessels were very large, but which he had removed with this instrument with scarcely any hemorrhage resulting.

Dr. Palmer referred to a case of seeming elephantiasis of the vulva, but which was probably one of hypertrophy, very rare, perhaps unique, on account of the extent and breadth of its attachments. When last under observation, in the Dispensary of the Medical College of Ohio, it was overlapping the vulva, some $3\frac{1}{2}$ inches in the long diameter, $2\frac{1}{2}$ inches broad, and $1\frac{3}{4}$ inches thick, irregular in shape. It had grown from the labia minora of both sides, and the whole anterior vaginal wall up to the cervix. The base at the upper part was softer and narrower than below.

The patient had syphilis, he thought, and was advanced some five or six months in utero-gestation. On which account he simply placed the patient under anti-syphilitic treatment and dusted the tumor with iodoform. It had decreased in size somewhat. He thought any operative procedures on it were contra-indicated for the following reasons:

1st. It might possibly decrease in size to a greater degree by further constitutional and local treatment.

2d. Its removal was not absolutely necessary to effect delivery. The

portion in the vagina was soft enough to become flattened down by pressure, and if necessary the perineum might be incised at either side.

3d. Any operative procedures in the present varicose condition of the parts, rendered so by pregnancy itself, would subject the patient to unnecessary risks from hemorrhage, primary or secondary.

4th. If the tumor continued after delivery, its removal by the galvanocautery or thermo-cautery would be easier and safer.

Dr. Wenning, in closing the discussion, said that, as stated in his paper, some confusion as to the pathology of elephantiasis seems to obtain with nearly all authors in cases of this nature. The only writer that gives something of a positive statement in diagnosis is Hildebrandt, who excludes elephantiasis if the base of the tumor is not implicated in the hypertrophy, otherwise the enlargement is one of simple hypertrophy. In the essayist's case the labia majora were not only not enlarged, but even atrophied, contrary to the rule in elephantiasis, which in the vast majority of instances attacks these parts of the external genitals in preference, either by themselves or in conjunction with the labia minora or clitoris.

An important question is the relation of the condylomatous growths to the tumors under discussion. Whilst almost all authorities admit that some irritant, in the form of an infectious discharge—be it of a syphilitic nature or of a gonorrhœal or gleet character—causes these mucous growths, some writers endeavor to make a distinction between the former and latter by the appearance of the condylomata, regarding the elevated variety—*c. acuminata*—as non-syphilitic, whilst they consider the flat mucous patches as indubitable evidences of syphilis. Should this latter theory be correct then the case in question would become still more uncertain in regard to its specific character, because the condylomata were all of the sharp variety.

Incidentally the speaker would remark in reference to the origin of condylomata, after gonorrhœal or so-called non-syphilitic discharges, that syphilis has occasionally been communicated by a supposed gonorrhœal discharge where the latter has probably been the result of an urethral chancre. He could hardly credit the statement that the irritation produced by masturbation alone should give rise to condylomata, much less to these enormously hypertrophied growths, although he would admit that by such a process, long continued, elongation of the nympha might be produced.

To a question whether he regarded his case as specific in character, the speaker replied that, in the absence of any other explanatory cause, he was inclined to this opinion and acted also accordingly in the treatment of his case, which he put under the influence of bichloride of mercury and iodide of potassium. Since the operation there has been no recurrence of any of the growths and, what is very singular, her cough disappeared immediately after the removal of the tumor. This was so

striking to the patient herself that it was the first thing to which she called the speaker's attention after the operation. She is now in perfect health. (A subsequent still closer examination, both of the mother and child, revealed no further evidences of syphilis).

Dr. Miles presented the following report of cases: "Pregnancy in conjunction with complete procidentia and delivery with uterus outside the body." This paper will be published with next proceedings.

OBSTETRICAL SOCIETY OF PHILADELPHIA.

Stated Meeting, Thursday, May 3rd, 1883.

The President, R. A. CLEEMANN, M.D., in the Chair.

Dr. Wm. Goodell related the history of

THREE STUBBORN CASES OF VESICO-VAGINAL FISTULÆ SUCCESSFULLY TREATED AFTER THE OPERATION WITHOUT THE USE OF A CATHETER

The first one, after a non-instrumental labor lasting from a Tuesday evening, when the membranes broke, to a Friday night, found that her urine dribbled away immediately after the birth of the child. The fistula was situated so close to the cervix as to implicate it, and was quite large. Sixteen months after the accident she was operated on by a distinguished surgeon, whose success in uro-genital fistulæ is very great. He turned the cervix into the bladder and successfully closed up all the rent save a small portion of it. On this fistula he operated three times without any union whatever. In each instance the urine dribbled away before the stitches were removed, and on two occasions an alarming hemorrhage came *per vaginam*. This information *Dr. Goodell* obtained from the surgeon, himself.

Early in 1877 *Dr. Goodell* operated on her at the Hospital of the University of Pennsylvania, and put in Sims's self-retained catheter. Eight sutures were needed to close the opening. The next day a hemorrhage from the bladder, possibly menstrual, took place and lasted several days. A fever also set in which gave some alarm. When the stitches were removed very little union was found to have taken place. Four months later *Dr. Goodell* operated for the second time, and thinking that the vesical hemorrhage in the preceding operation was caused by the irritation of the self-retaining catheter, he treated her without one. The first twenty-four hours her urine was drawn off every four hours, but afterwards she was allowed to pass it herself. No hemorrhage occurred, and perfect union took place.

The second case was also one of tedious labor in which the forceps was not used. The fistula at first was a very large one, and was most skillfully closed up by an excellent surgeon. A very small fistula, however,

remained at each angle of the wound. These defied repeated operations on his part, and the case finally drifted into Dr. Goodell's hands. Twice the latter operated at his private hospital on these fistulæ, using the Goodman self-retaining catheter, but each time vesical and uterine tenesmus set in and the result was a failure. Both fistulæ were then burned with the actual cautery, and one of them closed up, but the larger one resisted this treatment, as well as that by nitric acid. He then operated upon it a month ago for the third time, dispensing with the use of the catheter. The lady was instructed to pass her water before the desire was urgent. Neither vesical nor uterine tenesmus occurred. The stitches were left in for fourteen days and union was complete. The third case was the result of a short labor, and the cause of the fistula is obscure, as the lady was attended by a midwife who pulled and tugged away at something after the birth of the child. The late Dr. Lenox Hodge had operated five times upon it, closing all but a small fistula which lay at the junction of the neck of the bladder with the urethra. Dr. Goodell closed this fistula at the Hospital of the University three weeks ago with eight stitches, and fearing that the catheter would interfere with union dispensed wholly with it. The success was complete.

From these cases and from others which he had met with, Dr. Goodell was led to think that the catheter might, as a source of irritation, oftener be dispensed with very advantageously in the treatment of these fistulæ. He cited the practice of the late Dr. Simon, of Heidelberg, who was a very successful operator and yet rarely resorted to its use. He also called attention to the fact that in these cases, and in the very great majority of the cases he had met with, the forceps had not been resorted to, showing that it was not the use of that instrument, but its neglect or the delay in its use that caused the mischief. In fact he could not recall a case in which the lesion could be attributed to instrumental delivery. In the general experience of surgeons very small vesico-vaginal fistulæ were harder to cure than moderate-sized ones. One reason for this is attributable to the fact that they usually are found in sites difficult to reach; and another that the operator is unwilling to enlarge the small opening by bold incisions and fails from too small a denuded surface. Including the one previously referred to, he had closed two of them by means of the actual cautery.

Dr. Albert H. Smith remarked that these cases were of great interest. He had been taken by surprise when Dr. Simon announced his plan of treatment without the catheter, as he had been afraid of the strain on the stitches resulting from the accumulation of urine in the bladder. The presence of the self-retaining catheter must necessarily be a source of irritation and vesical tensesmus. The small holes in its bulb may become occluded by mucus or clot, and then it would act as a plug instead of a drain. In these cases in which the loss of substance in the vesico-vagi

nal septum has been very great and the mucous surface of the bladder has been prolapsed into the vagina, the capacity of the bladder becomes small and it must be emptied frequently or the tension on the stitches becomes too great.

He had been gradually led to the conclusion that it would be better not to use the catheter after trachelorrhaphy and perineorrhaphy unless called for by special circumstances. There are cases in which in consequence of mental influence or the effect of position the patient can not pass her water for weeks after labor in which no injury or long or undue pressure has occurred.

Dr. R. P. Harris has recently operated for the restoration of a very long perineum, the last stitch was almost on a line with the orifice of the urethra, and the nurse was not able to introduce the catheter. He placed the patient in a sitting position to pass her water and used a male catheter tied on the tube of a Davidon syringe to wash out the vagina.

Dr. Goodell is by no means a convert to treatment in this class of cases without the employment of the catheter. He has been too successful with it. He prefers the Goodman self-retaining instrument but he always makes certain that it did not infringe on the wound. He has recognized the influence of mind and of position on the ability to pass water and he thinks the use of ergot, so general before the third stage of labor, is one cause of the difficulty as it is quite possible that it may cause a spasm of the urethral constricting fibres. He would like to dispense with the use of both catheter and syringe after perineorrhaphy as he has found injuries to the anterior angle of the wound by the syringe and the fingers of the nurse while introducing the catheter. He has been in the habit of putting one stitch through the sound skin above the denuded surfaces to prevent this injury. In one case recently the Goodman catheter slipped out 24 hours after perineorrhaphy and he did not replace it, the wound healing. He always uses the catheter after trachelorrhaphy.

Dr. Goodell also exhibited

TWO OVARIAN TUMORS, ONE OF THEM OF DOUBTFUL CHARACTER.

The one of doubtful character was removed from an unmarried woman aged 27, who had not menstruated for over a year. It was first discovered nine years ago but gave no trouble until two and a half years ago, when ascites set in. She had been tapped fourteen times when Dr. G. first saw her. She was very thin, pale and so weak as to keep her bed. He recognized a hard tumor floating in the ascitic fluid, giving the feeling of ballottement and diagnosticated it as either a solid ovarian tumor or a padunculated fibroid.

On the 18th of last April he removed it at the University Hospital and found it to be a hard solid nodular tumor of the right ovary with evidences of papilomatous degeneration. It had merely omental adhesions and had

a long slender pedicle twisted many times on its axis. It was evident that the ascitic fluid was secreted directly from the tumor and did not come from pressure on abdominal veins or from irritation of the peritoneum.

The other cyst was removed also at the Hospital of the University and on the same day from a married woman aged 20 who noticed it two months after her marriage and about four months ago. The cyst was as large as the adult head, was apparently attached to the womb which was drawn upwards, and gave a measurement of 4 inches. It was operated on early because it caused great vesical disturbance. The lower portion of the cyst was found enveloped in the broad ligament close up to the womb and had to be enucleated. It was this condition that gave the symptoms of uterine attachment. The cyst was that of the left ovary, but as the right ovary also presented tokens of degeneration it was also removed. Both women recovered promptly although the first one had on the third day a severe attack of mumps which appears to be prevailing in this city as an epidemic. The ascitic fluid which was straw-colored and syrupy was not examined microscopically.

Dr. M. O'Hara wished to know how *Dr. Goodell* could decide quickly between mumps and septic parotitis. He also spoke of the reflex action of the sexual organs as shown by the frequent occurrence of salivation during pregnancy. In a recent case of cancer of the rectum the first symptom observed was excessive secretion of saliva.

Dr. Albert H. Smith remarked that mumps was a very interesting and very perplexing disease. He has seen cases of extension of the disease without retrocession, in adult women to mastitis and ovaritis. The swelling of the parotid gland being rapidly followed by the involvement of the sexual glands, the inflammation of the ovaries being accompanied by local peritonitis. A singular question was raised by the case of a young man who went to Florida directly after marriage and on the return trip by sea experienced a severe attack of mumps, it was complicated by orchitis the inflammation being of high grade with great increase of temperature and rapid pulse. No atrophy of the testicle has occurred, but the union has been sterile and there is no known fault on the part of the wife. The semen has not been examined microscopically to ascertain the presence of spermatazooids. The mastitis accompanying mumps has never in *Dr. Smith's* experience run into suppuration but is accompanied by febrile action of a high grade. He has seen the ovary the original point of attack the inflammation of the mammary gland being later. It is a marvel of pathology that this disease which affects in childhood the salivary glands only should in adult life affect the sexual glands also. He has never seen a case of atrophy of the testicles following mumps.

Dr. Goodell recognized mumps in this case by his experience in two previous cases of mumps with severe symptoms in adults. The pulse

does not become so frequent as in septicæmia, and the eye remains clear and does not acquire that glassy appearance so indicative of a fatal issue. Dr. Goodell has never seen the involvement of the breast and ovary. A peculiar relation between the sexual organs and the glands of the neck is shown by a habit of the Roman matron, who measured the throat of her daughter before and after the night after marriage to ascertain if the young husband had properly performed his marital duties and if they had been properly received.

Dr. Albert H. Smith exhibited a set of hard rubber

URETHRAL DILATORS.

This set consists of ten pieces with two handles into which they can be screwed; the smallest bougie is twenty millimetres in circumference at the point and twenty-eight mm. at the largest part, the tapering in each bougie being eight mm. and a difference of six mm. between each one and the largest circumference of the next in the scale. The largest one is eighty-two mm. at the largest part, and would be useful as a rectal dilator. He had been very much surprised at the statement made by Dr. Emmett at the last meeting of the Gynecological Society in Boston, that dilation of the urethra almost universally causes laceration and is followed by permanent incontinence of urine. Dr. Smith has been in the habit of doing it frequently and fearlessly, without hesitation, not only in disease of the urethra and bladder, but for exploratory purposes, and for the removal of stone, but also as a step in the operation of anterior elytrorrhaphy, that by means of a finger in the bladder he may judge of the thickness of the walls in denuding the vaginal surface and place his sutures satisfactorily. He has never had incontinence of urine to last over twenty-four hours from this procedure.

Dr. R. P. Harris had seen a large number of dilatations of the urethra without any bad effect. He would consider the method of Dr. Smith better than any other plan, as it would make a perfectly even and uniform pressure on every portion of the urethra, with a very gradual action, free from the dangers incident to the opening of any form of instrument with blades.

Dr. Goodell was much obliged to Dr. Smith for exhibiting these instruments and would get a set of them. He has entirely dropped Simon's dilators and has for some time been using his little finger as the best dilator. He has not had any trouble from laceration or incontinence. In one case in which he resorted to dilatation and treatment to the mucous surface of the bladder as a cure for cystitis following labor, incontinence remained for a long time, but gradually disappeared. He knew of laceration and incontinence in two instances resulting from the thumb as dilator. Dilatation alone is a good treatment for many cases of irritable bladder.

Dr. Wm. H. Parish narrated the case of a widow operated on by

Dr. Goodell, by dilatation for the relief of a very aggravated case of irritable bladder, the result of a gonorrhea contracted years before from her husband, and which had been followed by cystitis. It was greatly relieved for several months, but not cured by dilatation as the relief was only temporary. The patient passed under the care of Dr. H. Lenox Hodge, who cauterized the urethra by means of Paquelin's cautery. In consequence of the illness and death of Dr. Hodge, she came again under the care of Dr. Parish, who commenced treatment by the injection of a solution of nitrate of silver, very strong at first but weaker on subsequent applications. The trouble has passed entirely away. There are two causes of fissure in dilatation, the first is too rapid expansion of the dilator; the second, changes in the mucous membrane, as from inflammatory action particularly if caused by genorrheal poison.

Dr. Chas. H. Thomas had lately produced a set of nickle-steel instruments of about the same taper, and for the same purpose as those exhibited by Dr. Smith. The set consisted of sixteen pieces, there was one-and-a-half mm. as the scale, and each dilator tapered five mm. from the point to the largest circumference of the shank, they ranged from twenty-five to fifty mm. He has tried in some cases, using every second instrument, making rises of three mm., but has found that the pain was increased by so doing. He has never known of a case of incontinence caused by dilatation, but has heard of such from the hands of two celebrated surgeons of this city. He thinks dilatation to the size of the finger, a good treatment for the relief of irritable bladder in connection with irritation of the urethra and neck of the bladder. He related the history of two cases in which this condition was complicated and made persistent by sphincterismus of the sphincter-ani-muscle; dilation of the urethra in these cases, although a benefit did not cure the trouble, but where to this was added dilatation of the sphincter ani so that two fingers could be introduced back to back and a good dilatation secured, the cases were permanently cured.

Dr. B. F. Baer has practised dilatation of the female urethra a number of times and has had no instance of continued incontinence. He would however question the propriety of ever using a large size dilator, except for the purpose of removing a calculus from the bladder and even in that case he thought it might be better to allow the stone in the grasp of the forceps to finish the dilatation, than to use mechanical dilators to secure the full extent needed. In one instance, incontinence lasted several weeks after dilatation, but final recovery was complete; solutions of carbolic acid having been applied in the meantime for the cure of an irritability of the bladder and urethra.

Dr. Parish would like to hear from Dr. Smith respecting the indications for probable success in treatment by dilatation of the urethra for the relief of irritation of the bladder.

Dr. Smith in reply to *Dr. Baer* remarked that no cavity of the body should ever be dilated beyond the actual necessities of the case; such a principle is unquestionable; but no form of dilator could be worse than the irregularities and roughness of a calculus, increased in size as it would be by the grasping forceps, which would present but two points of contact with the urethra and render laceration quite probable. In a patient recently under his care, he had reason to suspect the existence of papilomatous growths on the mucous surface of the bladder; he dilated the urethra, using the largest size of *Simon's* dilators, and completing with a *Molesworth* dilator expanded very slowly. He was able to evert the bladder through the urethra, and removed the vegetations by means of scissors. There was no laceration nor incontinence resulting from this procedure. The danger is in too great haste. In reply to *Dr. Parish*, he said that dilatation is usually resorted to for exploratory purposes, removal of stone growths on the vesical wall, or to ascertain the thickness of the wall of the bladder, and to introduce a finger into the viscus to guide the sutures in plastic operations upon the finger vagina. Irritability of the neck of the bladder can generally be relieved by dilatation, but it sometimes fails to cure. *Dr. Smith* prefers hard rubber to plated metal as the material for the dilators, it is lighter in weight, is not liable to corrosion and is more easily kept clean. He thinks the multiplicity of instruments in *Dr. Thomas' scale* a disadvantage, and that time is lost and irritation caused by introducing several instruments in place of allowing one to remain a longer interval.

Editor's Table.

THE TREATMENT OF UTERINE DISEASES, by means of the *Hot Air Bath* and *Hot Vaginal Douche*.—We have a very readable contribution to the management of many forms of uterine disease, by *Dr. Allan Mott-Ring*, who is in charge of a Sanitarium, chiefly for women, in the vicinity of Boston. *Dr. Mott-Ring* proposes to treat almost the entire range of uterine diseases by the *Hot Air Bath* and the *Hot Vaginal Douche*. To give his method more satisfactorily we quote as follows at some length:

"Having obtained from the patient as full and complete history of her case as possible, and after making a careful examination to ascertain the exact nature of her trouble, I proceed to restore the general circulation—which in nine cases out of ten is seriously impeded—by means of the "Hot Air Bath." For the first week I do not advise a temperature of over 125° F.; but by the end of a month the temperature is increased to 135° F., and 140° F. The patient is allowed to remain at these temper-

atures until the perspiration starts freely, and all feeling of cerebral congestion has fled. This usually takes from twenty to thirty minutes. I rarely advise, in any case, remaining beyond the latter period. As a precautionary measure, I have the head enveloped in a bandage almost dripping with cold water; and where the perspiration does not start freely, the patient suffers, as is usually the case, from cold feet, her lower extremities are placed in a foot-bath at a temperature of 110° F.

The patient being now in a delightful glow of heat, she passes to the shampooing room, which has a temperature a few degrees lower than the "Hot Room"; and after going through the usual process of being washed, rubbed, and massaged, the attendant, who, in every instance, *must* be a woman fully competent and willing to faithfully carry out, in the minutest details, the physician's instructions, proceeds to administer the "Hot Vaginal Douche." For this purpose I have a reservoir holding four gallons of water, and so constructed as to show on its anterior wall, by means of a set thermometer, the exact temperature. From this, by means of rubber tubing to which is fitted a glass, many-holed, bulbed nozzle, the water is conveyed to the parts. The attendant carefully passes the nozzle high up in the vaginal canal, and by moving it herself, or instructing the patient to do so, brings the flow of water in contact with every part. During this process the patient lies on her back upon the warm marble slab, supported by the head, hips, and heels, on inflated rubber cushions. Where the inflammation and ulceration are extensive, or where there is much congestion, a larger quantity of water is employed. Having continued this drenching from five to fifteen minutes, the patient is carefully sprayed off and dried, enveloped in a blanket, and taken to the *cooling or rest room*, and placed upon a bed where she is advised to remain for one or two hours.

The wonderful sense of relief afforded by this, at every step, pleasant treatment, frequently enables patients to immediately fall into a refreshing sleep from which they awake invigorated. I always advise perfect quiet, after the treatment, among the patients, in order to encourage sleep.

I rarely repeat this treatment oftener than three times a week, having found from experience that considerable time must elapse between each bath and douche in order to allow nature an opportunity to set up a healthy reaction.

On the intermediate days I have the patient *massaged* and *percussed*, by a skilful masseuse, with peculiarly-constructed rubber percussion-balls; and, after retiring for the night, she is dry-rubbed for twenty minutes, which, in most instances, produces refreshing sleep."

Dr. Mott-Ring resorts to electricity in many cases, as do most gynecologists. He insists, however, that this agent should not be entrusted to the nurse or patient—but should be applied by the physician himself. Furthermore, there is no advantage, in his opinion, in the use of the

strong currents—rather the best effect is obtained by commencing with the minimum force capable of producing contractions of the muscles.

Other agencies are remarked upon in the paper, as *massage*, the *Swedish movements*, etc., but the peculiar use of *heat* in the bath and the *douche* are the important matters presented.

A YEAR'S WORK IN OVARIOTOMY.—Dr. William Goodell, of Philadelphia, reports in full his experience for one year; that is the year 1882. During the year he operated on twenty-five cases of complete ovariectomy with six deaths. This mortality is perhaps in excess of the best results as reported by the recent experiences of the English operators. But Dr. Goodell proceeds to remark, "In not a single instance have I declined to operate; for I have given every woman her chance."

Dr. Goodell gives a full table of his cases, and it is something remarkable that of his twenty-five cases during one year, *twelve* of them were cases of double ovariectomy.

Considerable space is taken up by the doctor in explaining the details of his fatal cases; indeed we think there is a degree of frankness in this matter rather unusual. Coming back, however, to the relative degree of mortality, he remarks: "The results of my cases are not so good as those of British ovariectomists; but these gentlemen do not publish their incomplete operations, nor the cases on which they decline to operate. Without these data no just estimate can be made of individual success. My statistics, however, compare very favorably with those of the Vienna General Hospital for 1881. During that year "ovariectomy was performed 64 times, with 34 recoveries, 25 deaths, and one woman discharged with *marasmus*."

A variety of practical lessons and suggestions are drawn out in the paper, but we have called out the important matters for our present purpose—that is to show the excellent work of one American surgeon for the past year in this department of our work.

CANCER OF THE UTERUS.—Every physician will be called upon to determine the existence of *cancer*. Many women, perfectly healthy, have a morbid apprehension of a coming cancer. But every now and then we have evidences of a true cancer; what shall we do? How far shall we communicate the terrible probability to the patient or her friends? In a recent number of the *Philadelphia Medical and Surgical Reporter*, Dr. Goodell, of Philadelphia, makes the following suggestions which will doubtless meet the hearty approval of the professional thinker:

"Now, suppose a woman comes to you, and you diagnose cancer of the uterus, are you going to say, 'Madam, I am very sorry to tell you that you have a cancer?' No, don't you do that, I should not tell even if she asked me to tell her the truth; but in the majority of cases they do not

want to know, and will say to you, 'Now, doctor, if you find a cancer don't tell me.' No matter how good a woman is, or how fully prepared for the future she may be, the knowledge that she has a cancer is a terrible blow, and she at once gives up, begins to go down hill rapidly, and soon dies. I never, except in very rare instances, tell the patient that she has a cancer, but I always tell some member of the family, or a friend, exactly what is the matter. Suppose the patient asks straight up and down, 'Is it a cancer?' You do not want to tell a lie, and you do not want to say that it is a cancer. I get out of it in this way: I say, 'This is not that kind of cancer which you understand. This is not a hard cancer like that which comes in the breasts, and which is hopeless. You have a bad ulceration of the womb. It is not hopeless; there are cases which are cured.' About three years ago I learned a lesson on this point. I was asked by a physician to see a near relative of his. His suspicion was that it was cancer. I said to him, 'Suppose that this is the case, shall I tell the lady?' He replied, 'Yes; she ought to know; tell her by all means.' After I had examined and found a carcinoma, I said 'I am very sorry to say that this is malignant,' and then went on and told her in so many words what the trouble was. She never rallied from that. She made up her mind that her days were numbered, and that there was no use in doing anything, and in a short time she died. I say, then, never tell a woman that she has a cancer."

WHY DOES THE NURSING WOMAN NOT CONCEIVE.—This question is one of several sent to the *Michigan Medical News*; and to it the editor makes this reply:

We are not quite certain that lactation does prevent conception, although it is unusual for the woman to conceive while she is nursing. Every practitioner of experience must be familiar with cases in which the child has been weaned because of pregnancy, and not so much on account of a cessation of lactation as because of a popular belief that the coming infant needed the milk for its sustenance in utero. It may be that so much of the blood is required to keep up lactation that there is usually not enough left to rupture the walls of the Graafian vesicle and thus permit the ovum to escape to where it can come in contact with the spermatozoa. In not a few cases, however, there is no such deficiency of this ovarian supply and the woman conceives within three months of her parturition and while she is giving a plentiful supply of milk to a vigorous child.

SIXTEENTH ANNUAL REPORT of the Columbia Hospital for Women and Lying-In Asylum. P. J. Murphy, M.D., Surgeon in charge. The annual report of this institution, as usual, shows continued good work. There were under treatment during the year nearly 400 patients, and the

average daily number, exclusive of infants, dispensing patients and employes, was about 35. The medical and surgical cases in this hospital embrace nearly all the range of conditions of gynecological practice. To many of our readers it may not be known that this Columbia Hospital is a government institution and maintained chiefly by Congressional appropriations.

Foreign Gleanings.

TRANSLATIONS FROM THE FRENCH AND GERMAN.

[Prepared for the OBSTETRIC GAZETTE.]

RELATIONS BETWEEN PLEURO-PULMONARY AND UTERINE AFFECTIONS.

—Pleuritis after confinement is not an unusual occurrence, but it often presents rare forms. It may be the result of puerperal infection, when it is generally purulent, being also consecutive to peritoneal inflammation, propagated through the diaphragm. Again it results from taking cold, from exposure to the weather, especially when sitting in bed nursing the infant. A woman in our service recently confined, was taken with chills, fever and abdominal pain upon the third day. Examination revealed nothing, although it was certain there was a peri-uterine inflammation developing, which showed itself more plainly in a few days, although disappearing rapidly.

But in the meantime there were evidences of pulmonary congestion, followed by a slight pleural effusion. Another patient has her menses checked by taking cold, she has chills, vomiting, pain and delirium. Peri-uterine inflammation with light pleuritis was diagnosed, which entirely disappeared in fifteen days. It might be asked if the abrupt suppression of the menses was not caused by the pleuritis. But this question cannot be varied in the following case. A young girl entered the service with a purpura and urticaria, in whom the menses had been absent two months, on the approach of the third month she was attacked with a transitory diaphragmatic pleuritis lasting but four days.

In this case the uterine congestion appeared to have caused the pleural complication. Another young girl subject to menstrual irregularities to within a few months when she became regular, was taken suddenly with abdominal pain and symptoms of uterine congestion, together with a pleuro-pulmonary congestion, which for a long time remained the predominating phenomenon. In grave forms of puerperal inflammation, the infection is carried through the lumbar lymphatics to those of the inferior aspect of the diaphragm. But when the uterine affection is still not marked and there is no suppuration, and when the pulmonary complication has advanced rapidly, the cause is probably to be found in a re-

flex action. M. Potain observed a young girl who succumbed in three days to a diaphragmatic pleuritis and pulmonary gangrene, the result of suppressed menses. Generally a dry pleurisy of little gravity arises, even in the puerperal condition. In the majority of cases the congestion is participated in by the lungs, and in one instance M. Potain aspirated thinking he had pleuritis. When the peritoneal trouble is cured the pleuro-pulmonary accidents ameliorate. It is well then to examine these when a peri-uterine examination exists, whether of puerperal origin or not, as removing the cause goes far towards healing the complication.—*Hopital Necker, Prof. Potain.* M.S.

DEVIATION OF THE CATAMENIA.—Madame M., 38 years old, began to menstruate painlessly and regularly in her seventeenth year, married at 23, bore a daughter the first year and menstruated seven months after, continuing monthly during twelve years. At the end of this time she was troubled with a cough and abnormal respiration. Several physicians pronounced her tuberculous. After two years the congestion of the lungs had disappeared, to centre in the kidneys, causing terrible pain every month. During the menses she passed red urine, large clots of blood and shreds of membrane. In January, 1881, (a year later) her urine became redder, while the catamenial flow sensibly diminished. In April the uterine flow was scarcely a few drops, while she passed large quantities of very red urine. This lasted three or four days, when the urine became normal in hue and quantity. This was repeated on the following month. In December I was called in and found her on a straw bed, (she being unable to endure the heat of feathers) with the clothing elevated, so as to remove all pressure from the sensitive abdomen. She lay upon her back with limbs drawn up, urinating in a vessel placed beneath her. The bowels were bloated and sore, the pulse weak, and the whole condition one of great depression. The urine deposited large bloody coagula. Ten days later she was on her feet, the abdominal dimensions and sensibility normal, the urine clear, containing neither sugar nor albumen. The cervix uteri was healthy, the surrounding parts were not sensitive, the uterine functions were transferred to the kidneys. I prescribed ergot to be replaced by Apiol four days before the menstrual period, continued through it, when ergot was again resumed. Bromide potassium on retiring. January 10th, menses returned under former conditions. Two days before they were again due, I ordered two leeches to the cervix followed by puncturing. There was no pain, and but a few bloody clots from the uterus. Next month less bloating and renal pain, a little more uterine discharge, but copious red urine. The month following about the same. In May abdominal pain, well marked uterine discharge, less blood from the kidneys. June showed further improvement. July much pain, half the normal quantity by the uterus, and the urine

had lost its ruddy tint. August, continued improvement. September, menses nearly normal, urine showing blood only on the first day. October, period and urine normal. November, period abundant, urine clear, and so little pain that she could leave her bed on the third day. Sleeps on feathers; ergot and apiol suspended. December, everything normal, bromide discontinued, tincture of iron prescribed, general condition good. January, '83, in perfect health. A year of treatment was required to recall to the uterus a flux which was borne to the lungs and then to the kidneys. It was a case of pseudo-membranous dysmenorrhœa, or better, a slow exfoliation of the uterine mucus membrane. This pathological condition prevented the catamenial flux from this organ, and it appeared from the lungs and kidneys. In 1846 Oldham's first observations on the expulsion of uterine mucous membrane was published in the *London Medical Gazette*, attracting great attention. Tilt, several years later, made an interesting communication to the London Medical Society on the same subject. My savant preceptor, Dr. Bernutz, considered Oldham's case as one of an inflammatory state of the uterus, and not an individual affection. M. Courty says this exfoliation appears to be the result of a too great sanguine congestion, a sort of apoplexy of the membrane, with a peculiar disposition to exfoliate. The etiology seems still obscure, but this case is of great importance, showing that the membrane can exfoliate without any determining peri-uterine accidents. The flux is shifted to other organs, a new membrane is gradually formed, becomes vascular and able to support the monthly shock. The treatment seemed to me to have prepared, aided and facilitated the return of the menses to the uterus.—Dr. Carrigue in *Journal de Médecine Post.* M.S.

INTESTINAL LESIONS IN TYPHOID FEVER OF CHILDREN.—Most authors agree in considering the intestinal lesions of little importance in the typhoid fever of children. The ulceration is neither deep nor extensive, and the variety of hemorrhage and perforation is due to this. Diarrhœa, even, is not common, excepting with the youngest subjects, in whom slight causes call forth this trouble. Other lesions, as tumefaction of the spleen, alterations in the lungs and head, are found, but in a less degree than with adults; which fact has a diagnostic value. In small children its diagnosis is often beset with difficulties. At the beginning there is often no diarrhœa and eruption is rare and transitory. One point only is characteristic—the thermometric curve. Its debut is often marked by what appears an ordinary throat trouble, furnishing instances in which Wunderlich's axiom of 104° is not correct. Commencing with a local inflammation, a high temperature is the rule. It may commence with a pneumonitis, when it will be readily seen that it is not a typhoid pneumonitis. Thermometric curve will be peculiar and characteristic. This always complicates the prognosis. Tuberculous meningitis presents an-

other cause of error, as it is oftener accompanied by diarrhœa, as typhoid fever is by constipation, than is generally supposed. Relying on this symptom alone a double error is likely to be committed. Persistent headache is an accompaniment of meningitis, but it is difficult to appreciate this in infancy, and vomiting is rarer in typhoid fever. In meningitis there is a striking disproportion between the pulse and temperature. Functional troubles are but slightly marked. It often happens that the bronchitis, gastric disturbances, and diarrhœa are prescribed for in turn, without the thought that these different morbid conditions belong to one and the same illness. The statistics of the mortality are numerous and contradictory.

The younger the child the better the prognosis. It is not as grave as the eruptive fevers, for very young children, not having that attraction for diphtheria which the exanthemata possess. In dealing with so mild a disease too much medication should be avoided, being content at first to treat the most prominent symptoms. Abdominal tension should be met with warm water enemata, lime water or chamomile tea added if there be profuse diarrhœa. If the stools are disagreeable in odor carbolic acid should be used. Constipation should be treated by simple, glycerined, or enemata containing castor oil. An excessive temperature is not usual. Sponging with vinegar and water, or enveloping in a wet sheet is often all that is required. The cold pack, excessive doses of quinine and salicylic acid are pernicious. The latter, especially, being mostly eliminated by the kidneys is likely to cause albuminuria. West advises antimony and laudanum or Dover powder in delirium. Alcohol must not be used in the large doses recommended by some authors. Alimentation is of more importance than with the adult. It must not be forgotten that children require double rations, for sustenance and development. An adult can live for sometime upon himself, the child cannot. This fact must never be overlooked, although it often is in the acute diseases of children. Children under three years will be fed with milk alone, beyond that age soup may be added. A physician is sometimes consulted as to the advisability of removing a child from a locality in which the fever is epidemic. It is best not, if the mortality is not too great. The child will gain immunity for the future. Those passed ten years should be removed, however. — *Journal de Médecine Pratique*. M. S.

BRONCHITIS IN CHILDHOOD. —Bronchitis in children requires special study, not only for its frequency, but the peculiarities it exhibits at this age. Its rank is second in children's diseases, being oftenest met with up to the third year—beginning in the majority of cases at the sixth month. Children of this age being much exposed to the weather, and not possessing sufficient vitality to endure it. Sex seems to have no influence, but the spring and autumn months raise the figures.

Excessive cold, great variations in temperature, dampness, and winds from the North and East increase the disease. Atmospheric pressure nor ozone affect it. Impure air, remaining in poorly ventilated apartments, air filled with smoke and other effluvia, are exciting causes of a fourth of the cases. Many diseases are complicated or followed by it. It is especially liable to persist long after measles has disappeared in the patient. Rachitic children are more susceptible than others. The cause of this may be that these individuals have a delicate skin, perspiring freely and readily, predisposing to take cold easily. In those of tuberculosis parentage attacks are lightly set up and present changes. Bronchitis is usually accompanied by like processes in other organs, coryza intestinal catarrh, angina, favenium, ophthalmia, otorrhoë, etc. More rarely with hyperæmia of the brain, and it may give rise to hæmoptysis and hernia, anæmia and atrophy.

In bronchial catarrh we have swelling and hyperæmia of the mucus membrane with an abundant secretion of mucus. In chronic cases there is bronchiectasis and thickening of the walls of the vessels. It is not always limited to the large tubes, but passes into the most minute ones, even into the lung alveoles giving rise to catarrhal pneumonia. The changes in the lung tissue under these circumstances are seen as tough, bluish red infiltrations, often with emphysematous surroundings. On pressure a bloody fluid exudes filled with epithelial cells. These elements undergo fatty degeneration, we have pus and lung phthisis, or develops in the interstitial tissue a new growth which destroys the lung substance. Slight and harmless as it is, where limited to the larger tubes it becomes of the greatest moment, where it affects the smaller ones, the swelling of the mucous membrane being so great as to make them impervious to air. Even confined to the larger tubes in nurslings it may become a source of great danger. They cannot expectorate, the tubes are packed with the secretion, the blood is insufficiently oxydized, and the patient dies in a state of collapse. The constitution, the manner of nourishment, the immediate surroundings, the family history, the past illnesses and the complications, especially that of intestinal catarrh, effect the course of this disease. Of no other disease does a child suffer so many attacks, still is the prognosis favorable? The most striking symptom is the peculiar cough. It is not rude and hoarse as in laryngeal catarrh, nor painfully suppressed as in pleuro-pneumonia, nor of plastic character as in pertussis. It is severe, persistent, dry at first, and moist later on. The little child does not cough out and expectorate; his cough is broken off, the mouth closed, and the mucus swallowed or expressed through the nose. The face reddens, the eye tears, and often vomiting ends the cough attack. Older children may be taught to suppress the voluntary cough, as coughing exasperates the existing conditions. In simple cases little treatment is needed, in other cases opium in some

form must be used. With older children, inhalations of water medicated with chloroform, belladonna, balsams, and alkaline substances. Fever may be treated with digitalis or quinine. Tepid bathing is of great service in some cases. Emetics may be given to infants, rubbing the chest to cause them to cry out or cough. As prophylactic, flannel should be worn next the skin, cold baths be taken, and as much time as possible spent in the open air, with the balance of the time passed in airy, well ventilated apartments.—*Allg. Wiener Med. Zeitung.* M.S.

RETROVERTEBRAL ABSCESS IN INFANTS.—M. Guéniot discusses, in the *Revue des Invalides de l'Enfance*, an affection sometimes present with children in which diagnosis is extremely difficult. A retrovertebral abscess simulating meningocele, the etiology being obscure. He reports two cases. An infant fifteen days old presented in the dorsal region, just over the median line, a tumor about the size of a nut, fluctuating, increasing in volume during crying, without any surrounding induration, or the least change in the aspect of the surrounding tissues. The tegument was healthy, without a trace of œdema. It was uncertain whether it was congenital or had arisen after birth. Its size rapidly increasing, M. G. introduced an exploring needle and found pus, he made a large incision without recognizing an alteration in the bone. The child was making a good recovery when it died suddenly. In the second case the tumor was in the cervical region, and healed after incision. M. G. remarked that these tumors and hernia of the meninges of the cord had three characteristics in common—the seat of the tumefaction in the median line and the depths of the region, the tension and even a certain expansion under the influence of the infant's cry, the complete absence of œdema, and the preservation of the normal tint. Regarding the site, it is necessary to remember that in childhood, especially in the first years, there is no part of the body which is not capable of offering a nidus for suppuration. The second characteristic was regarded as pathognomonic of meningocele, can be explained by the numerous anastomoses between the veins within and without the cord. The third is occasionally met with in the abscesses of infants. In obscure cases the only resource is exploring puncture. M.S.

GLYCOSURIA.—Many authors claim glycosuria to exist in nearly every woman in the pregnant and puerperal condition. This has been proven incorrect; and this pathological state has been found only in women in whom the function of lactation has been brusquely suppressed.

M. Verneuil has noted this in nurses suffering from abscess of the breast, and Dr. Vacher has united the published facts in an interesting thèse. He says that in abscess where the nursing has ceased, the milk

still continues to flow into the breast, when its sugar is absorbed and passes immediatly into the urine. Properly speaking, it is lactose instead of glucose that is found in the urine. That the lactosuria has for its origin absorption from the mammary gland, is shown by removing the glands from animals, when this phenomenon ceases. The quantity of sugar is not large. Glycosuria under these circumstances does not make the prognosis more serious, as it disappears with the cause, nevertheless extreme caution should be used in operating on patients at that time. M. Verveuil has asked the pertinent question, whether this condition did account for the suppurations, diffuse inflammations, or even gangrene, which sometimes occurred in the recently confined women who were nursing. Twenty-five years ago he lost a patient upon whom he had operated, whose breasts secreted milk abundantly, and he has since persistently refused to operate during the period of lactation.—*Journal de Médecine Pratique*. M.S.

Abstracts and Selections.

I. — OBSTETRIC.

On the Use of Anæsthetics During Labor.—By Thomas D. Savill, M.D. In a paper recently read before the East Surrey District of the South-Eastern Branch of the British Medical Association, Dr. Savill indicates what he believes to be the main precautions, the observations of which would render the use of chloroform perfectly justifiable. 1.—There are certain women who have a tendency to flood at every confinement, and others in whom there seems an already too great relaxation of fibre—weak anæmic females in their eighth or tenth confinement; and to these it would be unadvisable to give chloroform, except for necessity. Happily, it is not these women who suffer the most pain, but rather those strong, healthy primiparæ whose pelves and general build approximate to the masculine type. 2.—We should not give it when labor is complicated with severe vomiting, or with acute heart or lung disease, unless there be imperative call for it. 3.—It should not be given to the full extent, except for operations, convulsions, or spasms of the cervix; and then it is most necessary that one person should devote his entire attention to it. 4.—The inhalation should be stopped directly we find the pulse becoming very weak, or the respiration irregular. 5.—Anything which makes us suspect a fatty or enfeebled cardiac wall should make us cautious in the use of chloroform. Here, as in cases other than those of labor, it is not the most extensive valvular disease (so long as it be attended by compensating hypertrophy), but the atrophied or degenerate wall that constitutes the source of danger. Unfortunately, the

signs of these conditions are subtle and uncertain. Fatty heart may be suspected by an exceedingly feeble cardiac impulse, combined with an almost inaudible first sound; or attacks of dyspnœa, vertigo, and syncope, in the absence of anæmia, or valvular lesion; or the copious deposit of fat in other parts of the body, and the occurrence of dropsy without adequate cause. A dilated heart may be suspected by increased area of præcordial dulness, combined with epigastric and venous pulsation, and a want of correspondence between the violence of the cardiac impulse and the strength of the pulse. Pericardial adhesions also form a great source of danger. They may be suspected when the heart's apex is fixed above its normal position, and does not shift with respiration; or when there is depression instead of protrusion of intercostal spaces over the position of the apex, giving a waxy character to the cardiac impulse. 6.—In all cases, we should take extra care to prevent the occurrence of hemorrhage after birth; by giving a full dose of ergot when the head reaches the perinæum; by ceasing the chloroform immediately it is born; and by rousing the patient from her lethargy as soon as possible.—*British Medical Journal*.

Imperforate Hymen Persistent in Labor.—Mr. H. Grey Edwards, B.A., M.B., B.Ch., of Bangor, writes:

At 11 p.m., April 25th, 1883, I was called to see S.O., primipara, aged 32, said to have been in labor since Monday morning, the 23rd ultimo. I found the patient suffering from severe "pains." On digital examination, I was somewhat surprised to find that the orifice of the vagina was completely closed by a tough membrane. Anteriorly, it was comparatively thin, and attached to the edge of the vaginal orifice, whence it sloped gradually backwards until, at the posterior wall, it was attached an inch and a half from the orifice. Here it was very thick, and gave the same sensation to the finger as the walls of the vagina itself. The foetal head could be easily felt through the tissue, which was perfectly lax, resisting all efforts at rupture with my finger.

Having decided to give the uterus time to do its best, I left, calling again at 4 a.m.; but, though the pains had been strong and frequent, things were much in the same condition. By sawing with my nail at the thinnest part, I eventually got the end of my finger in, and tore the hymen by drawing the finger backwards, until about half-way across, but I could not manage it further. I then waited an hour, in the hope that the remaining half would not be sufficient obstruction to delivery; but, "pains" becoming short and slight, I put on a forceps, and delivered without difficulty. The patient is going on satisfactorily.

I have reported this case under the belief that such a tough condition of hymen is most unusual.

It is medico-legally interesting, that one single act of copulation, in

spite of the seeming difficulties of the case, sufficed for impregnation. — *British Medical Journal*.

A Case of Cystocele Complicating Labor. — Mr. John H. Whitham, L.R.C.P.Ed., of Haworth writes:

On January 10th, a patient of mine, who was pregnant, complained to me that she had had "bearing-down pains" in the lower part of her body, and that she thought something had given way. I made a digital examination, and found a tumor protruding from the vulva. I could pass my finger behind it, and could recognize the os uteri high up and looking backwards; but anteriorly the tumor was attached. I concluded that it was a case of cystocele, and ordered my patient to preserve the recumbent posture, making frequent use of the catheter myself, to prevent accumulation and decomposition of urine. The case went on without any inflammatory symptoms until labor set in on the 29th ultimo. Early in the labor, the bladder and rectum were emptied. As the patient had a very roomy pelvis, I found that at first I could replace the tumor, and hold it up above the pubes by means of two fingers; but, as the pains became more intense, I was obliged to withdraw my fingers, and, in doing so, the bladder followed them. I then consulted with Dr. Dobie, of Keighley, and the result was that I gave the patient a full dose of ergot, placed her in the knee-elbow position, replaced the tumor and held it in position until the next pain brought down the head well into the pelvis. After this, there was no further trouble; the case was quickly and easily terminated without further complication.

I have reported this case, not because any extraordinary treatment was adopted, but because I had to deal with a complication which is apparently rare, since I have fruitlessly consulted on this point several well known midwifery books. — *British Medical Journal*.

Ergotine Suppositories. — M. Liebrecht, of Liège, has found that ergotine administered in this way is very rapidly absorbed, its action is energetic, and it provokes no pain. With smaller doses than are usually employed in hypodermic injections, equal or even superior effects are obtained.

The following formula is serviceable :

R. Dialyzed ergotine	1 ½ grams
Ol. theobrome	1 ½ grams
Vaseline	½ gram, M.

For one suppository; three may be applied weekly. The uterine affections, in which injections and suppositories of ergotine are of benefit, are: Fibroids, menorrhagia, metrorrhagia after labor, at the period of the change of life, or when tumors are present; finally in chronic metritis and endometritis. For hypodermic injection, M. Liebrecht uses exclusively pure dialyzed ergotine. — *Med. and Sur. Rep.*

II.—GYNECIC.

The Prevention of Insanity in Certain Cases of Nervous and Hysterical Women.—In our insane asylums throughout the country there are probably more women suffering from uterine diseases than from any other five or six diseases combined. There are female inmates in our asylums who might have been saved from such a fate had their real trouble only been appreciated in time. The female generative system is now recognized by scientists as the centre around which everything else revolves in a woman's constitution. The whole nervous system seems to be in direct sympathy with these parts, so that a number of diseases may possibly be simulated by what is termed "reflex action," when in reality the only disease present is found in the womb itself, or the ovaries. A patient may have dysmenorrhœa or painful menstruation; amenorrhœa or scanty menstruation; menorrhagia or profuse menstruation, caused by some uterine growth, perhaps. The uterus may be flexed or distorted anteriorly or posteriorly, thus rendering the uterine canal flexed instead of its being comparatively straight. Then, again, the mouth of the uterus may be torn by childbirth, if the patient be married. Finally, we may find her with enlarged ovaries, or ovaries which have undergone cystic degeneration. These are a few of the diseases, any one of which can produce such "reflex" symptoms or "phenomena" as "melancholia," "hysteria," "convulsions" and "cephalgia," or continued pains in the head. Any of them, if allowed to go without proper treatment, may sooner or later develop into insanity. These diseases are curable if properly treated. For the anteflexed uterus we can perform Dr. Marion Sims' operation of straightening the canal; for the lacerated cervix we have Dr. Emmet's able operation; and for the diseased ovary Dr. Robt. Battey, of Rome, Ga., has given us the remedy, that of removal of one or both of the offending organs. Heroic and terrible as this last operation may seem to you, it is, nevertheless, of great service to some poor suffering women.

There is no doubt whatever, in my mind, that a great deal of insanity in women could be prevented if a proper examination of the pelvic organs was made by a competent gynecologist before the patient is committed to an asylum. If uterine or ovarian disease is found to exist, she should be sent to a hospital where she would receive the proper treatment by a competent gynecologist. Graily Hewitt, of London, says that "there appears to be very good ground for the belief that some few of the cases of 'mental' diseases long regarded as calling only the attention of the alienist physician, are really *insanities* produced by diseases of the generative organs, susceptible of treatment and relief at the hands of the gynecologist."

The late Dr. Peaslee said he had met with several cases in insane

asylums where the cause of insanity proved to be curable uterine or ovarian disease. There should be some provision made by which our general hospitals could have a ward to which a patient supposed to be insane could first be sent, for a thorough physical examination. If uterine or ovarian disease is found to exist, she should remain and submit to proper treatment. Should this fail she could afterwards be sent to an asylum.

I understand that one of Brooklyn's wealthy citizens has recently founded an Infirmary for the treatment of women with uterine disease. I refer to Mrs. Manning, who was at one time a State visitor to a lunatic hospital, and learning that there were many insane patients therein suffering from uterine diseases, she determined to establish an Infirmary in Brooklyn where such sufferers might be scientifically treated, without charge, and thus save the alternative of removal to an insane asylum.

A few clinical reports of cases will suffice to show the importance of an exact diagnosis before committing a patient to an insane asylum.

A young couple were married and went on their bridal tour. In a week or ten days the bride became morose and peevish, and it was discovered that she was insane, when she was brought to New York, to consult Dr. Hammond, who said her insanity was of uterine origin. He called my father to see the case. He could learn nothing from her, as she was in such an excited state; but with the co-operation of her mother, they succeeded in getting a history of her uterine trouble, which had been of long standing. In a month she was much improved, and in two months the local disease was cured, and she was as gay and happy as before. Who can doubt but that it was better for the patient to be treated thus than to have been sent to an asylum?

A beautiful young girl was married, and in two weeks she manifested symptoms of insanity, and was sent home for treatment. I saw her with her physician. She had always had dysmenorrhœa, and an examination showed antelexion to an extreme degree. The neck of the uterus was incised antero-posteriorly.

After this she menstruated naturally, and her insanity was cured by the curing of her dysmenorrhœa, and she has remained well ever since.

A talented young girl, aged 18, of highly excitable nervous temperament, subject to hysterical attacks with mental disturbance, consulted physicians who treated her for some time without benefit, and then advised her parents to send her to an asylum, thinking its seclusion and separation from family influence would be favorable for recovery. As she was not insane, her confinement in an insane asylum made her almost mad. Fortunately she was removed before her disorder culminated in complete insanity. A short while after this my father and myself saw

her, and we could easily trace her nervous and mental disturbance to dysmenorrhœa from acute ante flexion. The cervix was incised, as in the preceding case, and soon this long suffering young lady was restored to health, happiness and usefulness. This shows the importance of investigating the condition of the pelvic organs in all women threatened with insanity. I have seen many such. Had I time I could detail cases of mental disease dependent on ovarian troubles, that were cured by Battey's operation, and that would have remained uncured if they had been sent to an asylum and not so treated.

I cannot refrain from mentioning the case of the lamented Horace Greeley. Medical men must learn the great difference between insanity and the delirium of acute disease. Here was a man affected with acute meningitis (or cerebro-spinal meningitis), and because he had delirium and was unmanageable he was, on the certificate of two physicians, sent to an insane asylum, where he died in a few days. We are not at war with the men, but with the system that permits such an abuse. There is just as much reason for sending a case of typhoid fever, with delirium, to an asylum, as there was in committing Horace Greeley to one in his last illness.—By HARRY MARION SIMS, M.D., in *Am. Psychological Jour.*

Ebstein on the Causes of Abdominal Tympanites in Hysteria.—Ebstein (*Neurol. Centralbl.*, Jan. 1883, p. 25) thinks that the meteorism which sometimes occurs very suddenly in hysterical women is owing to incontinence of the sphincter of the pylorus, and that air which is swallowed by such persons proceeds at once from the stomach into the intestines. Magendie has already mentioned that, in some persons who are able to swallow air, this latter does not return into the œsophagus, but proceeds through the pylorus into the bowel, which it leaves *per anum*; and in such cases the whole abdomen is distended, and presents the appearance of tympanites. Ebstein had already, in a previous publication, drawn attention to the circumstance that, in patients whose pylorus is no longer able to close from structural disease, acute tympanites of the bowel may be experimentally caused by development of carbonic acid in the stomach, which will then at once escape through the insufficient pylorus. He now relates two cases of hysterical girls in whom acute tympanites became rapidly developed. In one of them it persisted for a considerable time, while in the other it disappeared spontaneously shortly after it had come on. In one case it was so severe that it caused ruptures in the rete Malpighii, from sudden extreme distension of the abdominal parietes. If an effervescing draught were given, the tympanites was instantly increased; and from this Ebstein concluded that there was loss of power in the sphincter pylori, and—no other symptoms of gastric or intestinal derangement being present—that this was purely functional in character. Kussmaul, who has written an able paper on “the peristaltic unrest of the

stomach," considers (in contradiction to this) that in the empty stomach the pylorus is physiologically incompetent to close; but in order to eliminate this objection, Ebstein has made his experiments generally after breakfast, and nevertheless found almost immediate increase of existing tympanites, as shown by changes in the percussion-note and visible increase in the distension of the abdomen.—*London Med. Record.*

III.—DISEASES OF CHILDREN.

Malaria in Children.—The symptoms of malarial poisoning in children are very masked, and, indeed malarial affections as they relate to children have received but little attention, comparatively. The most positive knowledge we have on the subject is of a negative character: We know that the child does not shake in the cold stage of fever and ague. Dr. L. Emmett Holt reported at a recent meeting of the New York County Medical Society an analysis of one hundred and eighty-four cases of malaria in children as presenting at the Northwestern Dispensary of New York city, the analysis having especial reference to symptomatology. He found that in abrupt cases there is frequently vomiting, drowsiness, prostration, fever, severe pain in the epigastrium, etc., and on examination there will be found enlargement of the spleen and often tenderness over the hepatic region. In cases commencing less abruptly there is usually headache, generally frontal, muscular weakness, anorexia, constipation or diarrhoea, pallor of the face, a dark line under the eyes, nausea with occasional vomiting, tongue heavily furred, epigastric pain, and the patient hot and chilly by spells. Periodicity is not the reliable guide that it is in adults. In nearly all the cases observed the age was under eight years. Fever was one of the most important and constant symptoms. It varied as in the adult, and ranged itself under one of three heads: first, the temperature might be quite high at the onset and remain so for twenty-four, forty-eight or seventy-two hours, then resuming a remittent type; second, the rise might at first be slight, gradually increasing in intensity showing less periodicity and finally becoming continuous but not exceeding 103° ; third, the fever might be distinctly intermittent or remittent from the beginning. The usual range of temperature is between 101° and 103° , it very seldom reaching 106° , and never (in Dr. Holt's opinion) reaching those excessive degrees which it is the general impression that it sometimes attains. Sweating occurred in twenty-five per cent. of the cases, and was more constant than the cold stage. Convulsions occurred in four cases and recurred in two, all terminating favorably. Pain in the epigastrium was present in the majority of the cases, less frequently in the splenic and hepatic regions. In many cases vomiting occurred at the onset. In six cases there was incontinence of urine, in six painful micturition, and in a less number retention. No

single symptom can be relied on in children, the most important one, however, being enlargement of the spleen. The disease with which malaria is most apt to be confounded, in children, is typhoid fever. The temperature affords the only guide to differential diagnosis. When this is normal in the morning, after the third day, the affection is not typhoid.

In the discussion following the report, and participated in by Drs. J. Lewis Smith, John C. Peters and others, the correctness of the analysis was supported by the conformity of the results with those observed by the speakers. Dr. Smith was of the opinion that if the symptom run on in spite of the free use of quinine they indicate typhoid rather than malaria. Dr. Peters had seen cases of remittent fever in children and clearly traceable to sewer-gas, in which there was distinct intermittency.—*The Medical Age*.

Chamomile in Infantile Diarrhœa.—Dr. Christopher Elliott, Physician to the British Hospital for Sick Children (Practitioner Dec., 1882), endorses Ringer's claim for the great value of infusion of chamomile in infantile diarrhœa connected with dentition, and in which the stools are many in number, green in color, or are slimy and streaked with blood, and accompanied by pain and cramp. He gives ʒss-ʒj of the infusion to a child under one year, and double the quantity to a child over that age, giving it three times a day or oftener, according to the severity of the attack. He explains the rationale of this treatment by the power which chamomile flowers possess of subduing reflex excitability, a power residing in the volatile oil contained in them. Grisan was unable to tetanize, by means of strychnia, a decapitated frog which had been fortified with a dose of chamomile oil, and *vice versa* when reflex excitability had been artificially produced by means of strychnia, it could be calmed again by chamomile oil.—*The Medical Age*.

Gossip.

CHARLES READE, the novelist, is credited with having named a dog Tonic, because it was a mixture of bark, steal and whine.

"WHAT is the action of disinfectants?" was asked of a medical student. "They smell so bad that people open the door and fresh air gets in," was the reply.

ST. PAUL is to have a Health Officer, says the *Northwestern Lancet*; and no doubt the old gentleman needs a little attention, being now in his nineteenth century.

MEDICAL PROFESSOR TO RAW STUDENT: "Where is the glottis?" "I don't

know, sir. I think you put it on the shelf in the dissecting-room with the rest of your surgical instruments."

PADDY AGAIN.—When a gentleman at a banquet was speaking of a friend of his who had the smallpox twice, and died of it, an Irishman who was present inquired whether the man died of the first or of the second attack.—*Medical Times and Gazette*.

THE following diabolical joke is laid at the door of Dr. Oliver Wendell Holmes: A druggist in introducing his son asked the physician-poet if he did not see a resemblance between the offspring and his sire? "Well: yes," "I think I can see some of your liniments in his face." At last reports the poet was doing as well as could be expected.

THE HEALTH CURE.—Apropos to which we append the following anecdote: "Have you ever tried the faith cure?" asked a long-haired, sallow-faced stranger, addressing a stranger who sat behind him in a street-car. "I have," was the answer. "Do you believe in it?" "I do." "May I ask, then, of what you were cured?" "Certainly. I was cured of my faith."

THE following anecdote of Abernethy is being told: Being actively engaged in inserting a cervical seton in a "noble patient" who had requested that this be done, the patient exclaimed: "Sir, you give me excessive torture; will your seton do good?" "No," said Abernethy. "Then why do you insert it?" screamed the victim. "Because you told me to do so, and I will get five pounds for my work."

DR. S. W. DORA, Mattoon, Ill., says: "I take pleasure in bestowing a compliment on the alterative compound called IODIA. I have used it for the past two years as an eliminant and alterative *with great relief to my patients and perfect satisfaction to myself*. The ingredients entering into its composition are not new to the profession, but its virtue appears to consist *in the purity of the drugs used, and the method and elegance* of its preparation.

THE FUTURE OF PASTEUR'S GERM THEORY.—*Customer*.—"My nephew is just starting for Sierra Leone, and I thought I could not make him a more useful present than a dose of your best yellow fever. Would you tell me the price, please?"

Chemist.—"Well, ma'am, the germs are so difficult to cultivate in Europe that I would advise your waiting for the next West India mail, when I am expecting a nice, fresh supply from St. Thomas. Meanwhile we would advise our half-guinea traveling assortment of the six commonest zymotics, and could add most of the tropical diseases from stock, at five shillings each. We have some nice Asiatic cholera just ripe, but they are more expensive."—*Punch*.

DR. JOHN BROWN.—The world loses one of its genial and helpful spirits by the death of Dr. Jno. Brown, of Edinburgh. Few short papers have ever touched the heart of the world more pathetically than the little story of "Rab and his friends." The simple pathos of this charming sketch has won its way through the whole reading world, and is likely to confer on its author a long remembrance. Dr. Brown was a large-hearted, large-minded man, who had something of the humane element of John Wilson in him, with far more Christian purpose and character. He was a warm friend of this country, and many Americans cherish recollections of his hospitable home, where they often found him sitting between his two great dogs, of whom he was passionately fond.—*Christian Union*.